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Whistleblowing in the Public Sector

A good practice guide for workers and employers

public concern at work

November 2014

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Foreword

Workers are the most valuable resource in any organisation, not just because of what they do, but also because they have a unique perspective on frontline services. They are the eyes and ears that witness bad practice and wrongdoing that could harm individuals, colleagues, organisations and members of the public. It is essential that employers tap into this rich vein of intelligence and welcome workers who are courageous enough to speak out.

Encouraging workers to speak out has many benefits: it protects others by preventing further wrong-doing; it promotes a transparent culture; it protects and reassures the workforce; and it helps to maintain a healthy working culture and efficient organisation. An organisation's willingness to examine areas of potential weakness, and to listen to all staff, means that issues and concerns can be addressed promptly.

Whistleblowing needs to be encouraged by employers 'as the right thing to do'. It is clear that there needs to be a cultural change throughout the public sector and a very clear message must come from the top of every organisation that senior management supports workers who raise genuine concerns and that all such concerns raised will be taken seriously and investigated appropriately.

There is a wealth of good practice guidance available on how workers can raise concerns and how employers should treat those workers and deal with their concerns. This Guide draws on that good practice to set out clearly and simply the key aspects to be considered by both workers and employers.

We believe it is essential that all public sector employers embed the principles of this good practice within their organisation and that all workers should have the confidence to raise genuine concerns in safety and with the assurance that they will be treated properly.

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Our Purpose

The purpose of this Guide is to set out clearly and simply how public sector workers can raise concerns and what they should expect from their employer when they do so. It also provides guidance for public sector employers on how to encourage workers to raise concerns and how to deal effectively with concerns in an open and transparent way.

The past year has seen a number of significant developments in relation to whistleblowing in the public sector:

- Whistleblowing framework: call for evidence by the Government, June 2013
- the Government's response to the call for evidence, June 2014
- a report by the Westminster Public Accounts Committee (PAC) on whistleblowing, July 2014.

PAC said:
"Whistleblowing is an important source of intelligence to help government identify wrongdoing and risks to public service delivery……However, far too often, whistleblowers have been shockingly treated."

Public Concern at Work (PCaW) has reported that calls to its advice line from the public sector have increased by 41 per cent in the past year. It established a Whistleblowing Commission, which reported in November 2013.

In all of these recent developments, common themes have emerged, including:

- the overwhelming need for a culture change;
- poor treatment of whistleblowers;
- lack of knowledge about how to raise concerns; and
- defensive behaviour by workers and employers.

In response to the PAC report, PCaW said:
"This report demonstrates that a sea change in attitude towards whistleblowers is needed from the front line to the boardroom. Central government should see this as an opportunity to lead by example and change the experience of many whistleblowers."

As public sector audit agencies, we believe it is important that we add our voice to those sentiments. We have all experienced cases where concerns have been raised directly with us because the worker did not know how to raise concerns internally, did not have faith in internal arrangements, or had suffered as a result of raising concerns. This situation has to change. There needs to be an open and honest culture throughout the public sector, where workers have clear information on how to raise concerns (both internally and externally) and are encouraged to do so in the knowledge that they will be listened to and treated with respect, without fear of reprisal.

Section 1

Introduction

What is whistleblowing?

Generic definitions:

- *Bringing an activity to a sharp conclusion as if by the blast of a whistle. (Oxford English Dictionary)*
- *Raising concerns about misconduct within an organisation or within an independent structure associated with it. (Nolan Committee on Standards in Public Life)*
- *Giving information (usually to the authorities) about illegal or underhand practices. (Chambers Dictionary)*
- *(origins) Police constable summoning public help to apprehend a criminal; signal to stop work in the industrial age; referee stopping play after a foul in football.*

Public Concern at Work (PCaW)[1] definition:

A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. regulators, media, MPs)

Whistleblowing, or raising a concern, should be welcomed by public bodies as an important source of information that may highlight serious risks, potential fraud or corruption. Workers are often best placed to identify deficiencies and problems before any damage is done, so the importance of their role as the ‘eyes and ears’ of organisations cannot be overstated.

[1]Public Concern at Work is a whistleblowing charity. Established in 1993, it offers free confidential advice to people concerned about crime, danger or wrong-doing at work.

Whistleblower or Complainant?

A simple way to establish whether an individual raising a concern is a 'whistleblower' or a 'complainant' is to consider the nature of the concern:

- Does the concern refer to '*others*' e.g. the organisation, other staff, clients, the wider public? ....***Whistleblower***

- Does the concern refer to the individual *('self')* e.g. a personal grievance about terms of employment, pay, unfair treatment?...***Complainant***

Generally a whistleblower has no self interest in the issue being raised. However, the distinction may not always be clear cut. If in doubt, workers and employers can contact PCaW for advice (see page 49 for contact details). This good practice guide only applies to whistleblowing concerns.

Is whistleblowing encouraged?

Public Concern at Work
"*Whistleblowing can inform those who need to know about health and safety risks, potential environmental problems, fraud, corruption, deficiencies in the care of vulnerable people, cover-ups and many other problems. Often it is only through whistleblowing that this information comes to light and can be addressed before damage is done. Whistleblowing is a valuable activity which can positively influence all of our lives."*

Audit Scotland
"*Every public sector organisation needs to take whistleblowing seriously as it can both detect and prevent financial corruption and mismanagement."*

National Audit Office
"Whistleblowing is important to safeguard the effective delivery of public services, and to ensure value for money. It serves to protect and reassure the workforce, and to maintain a healthy working culture and an efficient organisation."

Northern Ireland Audit Office
"Whistleblowers have an important role to play in bringing information to departments about matters that are troubling them in relation to the proper conduct of public business."

Wales Audit Office
"Whistleblowing can act as a catalyst to real improvements in governance and accountability."

Public Accounts Committee
"It is essential that employees have trust in the system for handling whistleblowers and confidence that they will be taken seriously, protected and supported by their organisations if they blow the whistle."

Why is whistleblowing needed?

Whistleblowing best practice, and the legislation[2] to protect workers raising concerns (see Appendix 1), developed following a number of disasters and public scandals in the late 1980s and early 1990s:

- the capsizing of the passenger ferry the Herald of Free Enterprise outside the port of Zeebrugge, 1987;
- the explosion on the Piper Alpha oil platform, 1988; and
- the train collision at Clapham, London, 1988.

The **Bristol Royal Infirmary scandal** emerged in the early 1990s. A consultant anaesthetist had concerns about death rates following heart surgery on babies. When he presented data to his employers which supported his concerns, no action was taken so he went to the Department of Health. A General Medical Council (GMC) case against two heart surgeons resulted in one being struck off and one being suspended from operating for three years.

The GMC case prompted a public inquiry which reported in 2001. It made 200 recommendations for improvements in safety, management and regulation within the health service.

In each of these cases, workers had known of the dangers but did not know what to do or who to approach, were too frightened to speak out in fear of losing their jobs or being victimized, or spoke out but were not listened to.

[2]Public Interest Disclosure Act, 1998; Public Interest Disclosure (Northern Ireland) Order, 1998

A workplace culture which encouraged whistleblowing and where workers felt confident that they could safely raise concerns without reprisal or discrimination could have prevented these disasters and scandals or greatly reduced their impact.

Whistleblowing is therefore essential to:

- safeguard the integrity of the organisation;
- safeguard employees;
- safeguard the wider public; and
- prevent damage.

Section 2

Workers

Why should I raise concerns?

"The world is a dangerous place, not because of those who do evil, but because of those who look on and do nothing"

Albert Einstein

The disasters and scandals that prompted the introduction of Public Interest Disclosure legislation clearly demonstrate why concerns should be raised. The fear of reprisal and the absence of a means of reporting wrongdoing often meant that workers were unwilling or unable to voice their concerns, with the result that lives were lost and financial institutions collapsed. The legislation now provides a remedy for workers who have been victimised or dismissed for raising a concern.

While the examples on page 9 are extreme, the same principles can apply throughout public sector organisations. For example:

- If you work in procurement, are you aware of favouritism towards certain contractors?
- If you work in finance, have you noticed unusual accounting transactions being processed?
- If you work in the areas of environment or agriculture, are you aware of work practices which could seriously damage the environment?
- Are you aware of a colleague claiming for overtime which wasn't actually worked? Or claiming travel expenses for journeys not made?

These examples potentially all indicate malpractice, risk, abuse or wrongdoing. So the dilemma is:

Speak out?

or

Say nothing?

Still unsure?

The decision to raise a concern can be a difficult one. However, workers are the eyes and ears of organisations and responsible employers should want to address health and safety risks, potential environmental problems, fraud, corruption, deficiencies in the care of vulnerable people, cover-ups and other such issues. Addressing problems before damage is done should be the ultimate goal for both workers and employers.

The following case example shows the difference that whistleblowing can make.

Mid Staffordshire Hospital Trust

Helene Donnelly, a nurse in Stafford Hospital Accident and Emergency Department, raised concerns after she *"saw people dying in very, very undignified situations which could have been avoided"*. Examples included patients being so thirsty that they had to drink water from vases and receptionists left to decide which patients to treat. Nurses were not trained properly to use vital equipment, while inexperienced doctors were put in charge of critically ill patients. Some patients needing pain relief either got it late or not at all, leaving them crying out for help, and there were cases where food and drinks were left out of reach.

The public inquiry into the failings revealed one of the biggest scandals in the history of the National Health Service (NHS). Data showed that there were between 400 and 1,200 more deaths than would have been expected, although it is impossible to say if all of these patients would have survived if they had received better treatment. However, it is clear many were let down by a culture that put cost-cutting and target-chasing ahead of the quality of care.

The inquiry report made 290 recommendations for improvements in care across the NHS. Work continues on their implementation.

Public Recognition

Helene Donnelly was recognised in the 2014 New Year's honours list, receiving an OBE for services to the NHS.

Helene is also now an ambassador for cultural change at the Staffordshire and Stoke-on-Trent Partnership NHS Trust and takes staff concerns directly to the Chief Executive. She said *"I hope this [honour] is recognition for lots of other people trying to raise concerns and this is also for the positive change we're trying to encourage now."*

How do I raise a concern?

Good practice guidance strongly recommends that employers should have a whistleblowing policy in place, but this is not required by legislation. If your employer has a whistleblowing policy, you can raise your concerns internally in line with the policy. Be aware that:

- you are not required to have firm evidence before raising a concern, only a reasonable suspicion of wrongdoing;
- you are a witness to a potential wrongdoing and are merely relaying that information to your employer; and
- it is the responsibility of your employer to use the information you provide to investigate the issue raised.

Public Interest Disclosure legislation still applies if there is no whistleblowing policy in place. If this is the case, your concern can still be raised with management or the relevant prescribed person (see page 16). Most organisations have a number of ways to raise concerns.

Raising a concern internally

Step one

If you have a concern, raise it first with your manager or team leader. This may be done verbally or in writing.

Step two

If you feel unable to raise the matter with your manager, for whatever reason, raise the matter with a designated officer.

This person will have been given special responsibility and training in dealing with whistleblowing concerns.

If you want to raise the matter in confidence, you should say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of those listed in steps one or two, you should contact the head of your organisation and/or a Board Member (Non Executive Director, Chair, Audit Committee).

If you prefer, you may raise the matter directly with the department that funds your organisation.

If your employer **does not** have a whistleblowing policy, you should still report your concerns to your line manager or human resources (HR) department.

You also have the option of raising the concern externally.

Raising a concern externally

If you feel unable to raise a concern internally, or have done so but feel that the matter has not been adequately addressed, you have the option of approaching an external organisation, known as a 'prescribed person'.

A full list of prescribed persons and organisations, and the issues they are prescribed to deal with, is available on the Department for Business, Innovation and Skills website at www.gov.uk for England, Scotland and Wales, or the Department for Employment and Learning website at www.delni.gov.uk for Northern Ireland.

You can also contact PCaW at www.pcaw.org.uk for advice on raising concerns externally.

What types of concerns can I raise?

You can raise concerns about any issue relating to suspected malpractice, risk, abuse or wrong-doing. You need only have a reasonable belief that the issue has occurred, is occurring, or is likely to occur in the future. It is best to raise the concern as early as possible, even if it is only a suspicion, to allow the matter to be looked into promptly. You will not need to have evidence or proof of wrongdoing. As long as you have an honest belief, it does not matter if you are mistaken.

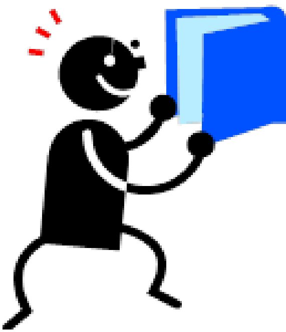
The following list illustrates the types of issues that may be raised:

- the abuse of children and /or vulnerable adults (physical or psychological);
- health and safety risks, either to the public or other employees;
- any unlawful act (e.g. theft);
- the unauthorised use of public funds (e.g. expenditure for improper purpose);
- a breach of the Employee Code of Conduct;
- maladministration (e.g. not adhering to procedures, negligence);
- failing to safeguard personal and/or sensitive information (data protection);
- damage to the environment (e.g. pollution);
- fraud and corruption (e.g. to give or receive any gift/reward as a bribe);
- abuse of power;
- poor value for money;
- other unethical conduct; and
- any deliberate concealment of information tending to show any of the above.

Case Examples

Actual examples of the types of concerns raised by whistleblowers include:

- A care worker raised concerns about the mistreatment of a dementia patient in a care home.
- A finance manager raised concerns about another manager's fraudulent use of an employer's credit card.
- A teacher raised concerns about poor value for money and poor service in relation to his school's new IT system.
- An employee raised concerns about irregularities in a health authority's estate management contracting arrangements.
- An employee raised concerns about abuse of position and misuse of public funds by a director in a local authority.
- An employee in a local authority leisure centre raised concerns about a colleague abusing overtime arrangements.
- A medical secretary in a health authority raised concerns that the majority of a colleague's work was for a consultant's private practice rather than the NHS.



Will my confidentiality be assured?

You can raise a concern openly, confidentially or anonymously. If you raise a concern openly, your employer should ensure that you do not suffer any detriment or harassment as a result.

It is not a requirement of the Public Interest Disclosure legislation to provide confidentiality; in fact it encourages workers to raise their concerns openly, but a good whistleblowing policy will provide a confidential port of call for a worried worker, and employers should respect any promise of confidentiality they make.

If you raise a concern in confidence, your confidentiality should be protected as far as possible. Your employer's arrangements should provide assurance that this will be the case. However, it may not always be possible to maintain confidentiality if this impedes the investigation. In such circumstances, it is vital that you are consulted and, if possible, your informed consent obtained.

Your organisation's whistleblowing policy should include:

- procedures for maintaining your confidentiality to the maximum extent possible;
- procedures for consulting with you and, where possible, gaining your consent prior to any action that could identify you; and
- strategies for supporting you and ensuring you suffer no detriment or harassment when confidentiality is not possible or cannot be maintained.

Even if your organisation's whistleblowing policy does not include assurances about protecting your confidentiality, your employer's duty of care towards you should ensure that they respect your confidentiality if you request it.

If your confidentiality is not protected, and you suffer detriment as a result, you may be able to seek recourse through an Employment Tribunal, as the following case example demonstrates:

Lingard V HM Prison Service (2004)

Lingard, a female prison officer, raised concerns with senior managers that a fellow officer had arranged for a bogus assault charge to be filed against a prisoner and had asked other colleagues to plant pornography in the cell of a convicted paedophile. Without telling her, Lingard's managers identified her as the source of the concerns. As a result, she was ostracised. She received no support from the Prison Service even though she was clearly suffering stress. A senior manager argued that Lingard's whistleblowing showed she was disloyal and she was eventually forced out. Lingard took her case to an Employment Tribunal citing detriment caused by her identity being revealed. Lingard won her case and received a substantial financial award. The Director General of the Prison Service said the case was indefensible and that lessons needed to be learned.

Source: PCaW, Where's Whistleblowing Now? 10 years of legal protection for whistleblowers

CONFIDENTIAL

Can I make an anonymous disclosure?

The purpose of Public Interest Disclosure legislation is to encourage the open raising of concerns, however, you can make a disclosure anonymously. Your employer should still accept concerns raised anonymously and give a commitment that they will be acted upon, with channels of communication, such as hotlines, provided to facilitate them.

You should be made aware, via your internal whistleblowing policy, of the disadvantages of raising concerns anonymously, including:

- Detailed investigations may be more difficult, or even impossible, to progress if you choose to remain anonymous and cannot be contacted for further information.
- The information and documentation you provide may not easily be understood and may need clarification or further explanation.
- There is a chance that the documents you provide might reveal your identity.
- It may not be possible to remain anonymous throughout an in-depth investigation.
- It may be difficult to demonstrate to a tribunal that any detriment you have suffered is as a result of raising a concern.

If you decide to reveal your identity to your employer during the process, your confidentiality should still be protected by your employer, as described on page 19.

What should I expect from my employer if I raise a concern?

Your employer should ensure that you are fully aware of your organisation's whistleblowing policy. The policy and procedures should clearly outline the process, including timescales and the nature of feedback that you can expect. They should also set out clearly who you should report to, and who to ask for support and advice.

In addition, you should expect that your employer will:

- formally acknowledge receipt of your concern;
- formally notify you who will be investigating your concern;
- offer you the opportunity of a meeting to fully discuss the issue, so long as you have not submitted your concern in writing anonymously;
- respect your confidentiality where this has been requested. Confidentiality should not be breached unless required by law;
- take steps to ensure that you have appropriate support and advice;
- agree a timetable for feedback. If this cannot be adhered to, your employer should let you know;
- provide you with as much feedback as it properly can; and
- take appropriate and timely action against anyone who victimises you.

Even if your employer's whistleblowing policy is not as comprehensive as it should be, you should not be deterred from raising your concerns with your line manager.

Section 3

Employers

Why is whistleblowing important to my organisation?

As an employer, you should ask yourself this question:

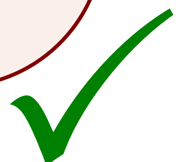
*"Do I **want** to know about malpractice, risk, abuse or wrongdoing in my organisation?"*

If your honest answer is 'yes' then you should take steps to encourage workers to raise concerns (see page 30). Effective arrangements for raising concerns should be a key part of a healthy organisational culture.

Workers who are prepared to speak up about malpractice, risk, abuse or wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation by identifying and addressing problems that disadvantage or endanger other people.

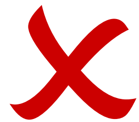
The benefits to your organisation of encouraging staff to report concerns include:

- identifying wrongdoing as early as possible;
- exposing weak or flawed processes and procedures which make the organisation vulnerable to loss, criticism or legal action;
- ensuring critical information gets to the right people who can deal with the concerns;
- avoiding financial loss and inefficiency;
- maintaining a positive corporate reputation;
- reducing the risks to the environment or the health or safety of employees or the wider community;
- improving accountability; and
- deterring workers from engaging in improper conduct.



The potential risks in discouraging whistleblowing include:

- missing an opportunity to deal with a problem before it escalates;
- compromising your organisation's ability to deal with the allegation appropriately;
- serious legal implications if a concern is not managed appropriately;
- significant financial or other loss;
- the reputation and standing of your organisation suffering;
- a decline in public confidence in your organisation and the wider public sector; and
- referral by a worker to an external regulator or prescribed person potentially bringing adverse publicity to your organisation (see page 16).



The key message for employers is:

LISTEN TO THE MESSAGE

DON'T SHOOT THE MESSENGER

In many organisations this may require a significant cultural change but it is essential that this change happens.

The British Standards' *Whistleblowing arrangements Code of Practice*[3] notes:

"..........the main reason enlightened organisations implement whistleblowing arrangements is that they recognise that it makes good business sense".

The Mid Staffordshire case (see page 14) shows clearly what can happen if concerns raised by employees are not treated seriously and dealt with properly. There can be very serious consequences and great personal suffering. However, on the positive side, the whistleblower is now an ambassador for cultural change at the Staffordshire and Stoke-on-Trent Partnership NHS Trust and takes staff concerns directly to the Chief Executive.

The following case is another example that clearly demonstrates the potential risks involved for both the employer and the employee when an organisation does not treat a whistleblower correctly.

[3]British Standards Institution (BSI) - BSI is the independent national body responsible for preparing British Standards. It presents the UK view on standards in Europe and at the international level. It is incorporated by Royal Charter.

Case example

Linda Ford, a financial accountant in the Northern Ireland Fire and Rescue Service (NIFRS), raised a number of concerns including:

- unapproved bonus payments for certain senior staff;
- unresolved corporation tax status; and
- manipulation of financial data.

She first raised the issues internally in 2010, in line with Public Interest Disclosure legislation and the organisation's whistleblowing policy, but they were not taken seriously. Ms Ford then brought the issues to the attention of the Northern Ireland Audit Office in May 2011, and to the NIFRS' parent department, the Department of Health, Social Services and Public Safety (DHSSPS), in July 2011.

The NIFRS suspended Ms Ford in August 2011 but she wrote to the Northern Ireland Assembly's Public Accounts Committee (PAC) in October 2011 with further allegations. On investigation, all but two of the allegations were substantiated, either fully or partly.

Ms Ford, who remained suspended for a year, returned to work in July 2012, and eventually received an apology from the Permanent Secretary of the DHSSPS for the way the case was handled. She also received financial compensation from her employer at an Employment Tribunal.

In this case the messenger was initially 'shot', but the message was eventually heard and acted upon.

Lessons to be learned

- All allegations should have been taken seriously.
- Allegations raised internally should have been investigated.
- Failure to deal with the matter properly led to escalation of the issues to PAC.
- The case has taken a toll on the health and wellbeing of the whistleblower; this could have been avoided if the case had been handled properly.

What types of concerns can workers raise?

Workers can raise concerns about any issue relating to suspected malpractice, risk, abuse or wrongdoing. The worker need only have a reasonable belief that the issue has occurred, either in the past, the present or is likely to happen in the future. Page 17 illustrates the types of issues that may be raised.

As an employer, you should ensure that your workers are fully aware of the differences between raising a concern and raising a grievance. It is important that you:

- have a whistleblowing policy in place which clearly distinguishes the two types of concerns (see below);
- have a grievance policy and procedure in place;
- make sure that these policies are accessible to all workers, e.g. on the intranet or notice boards, with posters in staff rooms, canteens and other communal areas highlighting the policies; and
- make sure that workers are aware of, and understand, the policies (e.g. through awareness training).

The difference between a whistleblowing concern and a grievance:

A whistleblowing concern is about a risk, malpractice or wrongdoing **that affects others**. It could be something which adversely affects other workers, the organisation itself and/or the public.

A grievance is a personal complaint about someone's own employment situation.

How can my organisation encourage whistleblowing?

If your organisation is serious about addressing misconduct, risk, abuse and wrongdoing, it must take steps to ensure that workers have the confidence to raise concerns openly. **Management commitment** to a positive and supportive whistleblowing culture is critical. It must be clearly stated in your policies and code of conduct, and managers must personally and explicitly commit to developing and maintaining an ethical culture. The head of your organisation should strongly endorse the policy. **There should be a clear message that no issue or concern is too small.** A checklist for employers is at Appendix 2.

Elements in encouraging workers to raise concerns include:

- a supportive organisational culture where raising concerns is welcomed;
- clear and explicit management commitment, from the top of the organisation, to an open and honest culture;
- a strong policy and code of conduct reinforcing the expectation of ethical behaviour from staff at all levels (see Appendix 3);
- clear roles and responsibilities in relation to dealing with concerns;
- clear procedures and lines of reporting for workers wishing to raise concerns;
- consistent handling of concerns raised, which should all be treated seriously;
- a specialist resource with detailed knowledge of whistleblowing, who can provide advice to management and staff and be an alternative to line management for workers raising concerns;
- effective awareness training for all staff so they know what concerns they can raise and how to raise them;
- effective training for line managers in dealing with concerns raised;
- a clear understanding of the benefits of whistleblowing (see page 25);
- continuing communication of your organisation's commitment to an open and ethical culture, through circulars, posters, emails and your intranet; and
- regular attitude surveys to determine the level of confidence staff have in arrangements for raising concerns.

As a line manager, what are my responsibilities towards staff who raise a concern?

Your organisation's whistleblowing policy should recommend that concerns are raised internally in the first instance, usually through a line manager[4]. It is essential that you, as a line manager, fulfil your responsibilities in a way that supports the person raising a concern.

Managers who receive disclosures from workers should:

- have a positive and supportive attitude towards workers raising a concern;
- record as much detail as possible about the concern being raised and agree this record with the worker;
- be aware of the process following the raising of a concern and explain this to the worker;
- make sure the worker knows what to expect, for example in relation to feedback on their concern;
- assure the worker that their confidentiality will be protected as far as possible, if they request this (see page 19);
- make no promises and manage the expectations of the worker;
- make clear that your organisation will not tolerate harassment of anyone raising a genuine concern and ask the worker to let you know if this happens;
- refer the worker to available sources of support, for example PCaW or a union; and
- pass the information as quickly as possible to those within your organisation responsible for dealing with concerns (usually someone within senior management), so that the appropriate procedures for consideration and investigation of the concern can be initiated.

[4] The option of raising a concern to a prescribed person is always available, even though it is not always included in organisations' policies (see page 16).

As an employer, what responsibilities have I to ensure confidentiality?

The best organisational culture is one in which whistleblowers feel comfortable raising concerns openly without fear of reprisal, and where the raising of concerns is welcomed. This makes it easier for the organisation to assess and investigate any issues, gather more information and reduce any misunderstandings.

Confidentiality

While openness is the ideal, in practice some staff will have good reason to feel anxious about identifying themselves at the outset and so your whistleblowing policy should ensure they can also approach someone confidentially. This means that their name will not be revealed without their consent, unless required by law[5].

While confidentiality should be assured if requested, you should point out potential risks to the worker:

- colleagues may try to guess the worker's identity if they become aware that a concern has been raised; and
- as any investigation progresses, there may be a legal requirement to disclose the identity of the person raising the concern, for example, under court disclosure rules.

As an employer you must ensure that, where the identity of a whistleblower is, or becomes, known, they are protected and supported. Appropriate and timely action must be taken against anyone who victimises the whistleblower.

CONFIDENTIAL

[5] British Standards Institute: Whistleblowing Arrangements Code of Practice

There are practical steps that your organisation can take to protect the confidentiality of workers raising concerns. These include:

- ensuring that paper files are properly classified as confidential and that electronic files are password protected;
- ensuring that the minimum number of people have access to case files;
- being discreet about when and where any meetings are held with the worker; and
- ensuring that confidential case papers are not left on printers or photocopiers.

The case on page 20 of this guide (Lingard V HM Prison Service, 2004) demonstrates the potential consequences of not protecting the confidentiality of a worker.

Anonymity

Whistleblowing policies should not actively encourage workers to raise concerns anonymously because this makes it difficult to:

- investigate the concern;
- liaise with the worker;
- seek clarification or further information; and
- assure the worker and give them feedback.

Your policy should emphasise that, by making their identity known, workers are more likely to secure a positive outcome. However, your organisation may still receive anonymous disclosures. These should not be ignored. You still need to assess the information provided and take appropriate action in line with your organisation's policy.

How should my organisation deal with concerns?

As an employer, you must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. You should consider a range of possibilities depending on the nature of each case:

- Explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns.
- Minor concerns might be dealt with straight away by line management.
- A review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment.
- There may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices.
- There may be a clear need for a formal investigation.

Having considered the options, it is important that you clearly document the rationale for the way forward on the case file. Your whistleblowing policy should make clear whose responsibility it is to decide on the approach to be adopted.

If necessary you can also seek advice and guidance from the relevant prescribed person (see page 16).

How should we conduct a formal investigation if required?

It is important that investigations are undertaken by people with the necessary expertise and experience. If your organisation does not have such staff, you will need to consider engaging external resources. Your internal auditors may be able to advise on this but may not be the best people to undertake the work if they do not have investigative qualifications. Where your internal auditors carry out investigations under your whistleblowing arrangements, and may also be involved in providing assurance on the effectiveness of those arrangements, any potential or perceived conflict of interest needs to be managed.

You should have documented procedures in place to be followed when conducting an investigation. These may be adapted from your fraud response plan or set out in a standard operating procedure.

Key considerations for any investigative process should include:

- employing investigators with the necessary skills;
- ensuring no conflict of interest between the investigator and the issue being investigated;
- having clear terms of reference;
- setting a clear scope for the investigation and drawing up a detailed investigation plan;
- clarifying what evidence needs to be gathered and how it will be gathered (document search, interviews etc.);
- deciding how best to engage with the whistleblower and manage their expectations; and
- ensuring that all investigative work is clearly documented.

How should we record, monitor and report on whistleblowing caseload?

Concerns raised by workers are an important source of information for your organisation. It is important that you capture key aspects so that the value of your whistleblowing arrangements can be determined and lessons learned where appropriate. Government departments should have procedures in place for receiving information about concerns raised in all arm's length bodies for which they are responsible. This can help identify concerns of a systemic nature.

In addition to individual case files, you should maintain a central record of all concerns raised, in a readily accessible format such as a spreadsheet or database. Any system for recording concerns should be proportionate, secure, and accessible by the minimum necessary number of staff.

The types of information recorded may include:

- the date the concern was raised;
- the nature of the concern (you may wish to compile a list of options relevant to your business) and/or the risk highlighted;
- who the concern was initially raised with;
- whether confidentiality was requested;
- the approach adopted (see page 34);
- the outcome, in terms of whether the concern was founded or unfounded;
- whether feedback was given to the worker raising the concern;
- whether the worker was satisfied with the outcome and if not, why not; and
- the date the case was closed.

Analysis of the information captured will allow your organisation to identify trends or business risks which may need to be addressed, and will also provide useful management information on the operation of whistleblowing procedures, such as:

- the number and types of concerns raised;
- how concerns were dealt with;
- the length of time taken to resolve concerns; and
- workers' satisfaction with the procedures.

Analysis of whistleblowing caseload should be reported regularly to senior management, the Audit Committee and the Board. This will help inform those charged with governance that arrangements in place for workers to raise concerns are operating satisfactorily, or will highlight improvements that may be required. Your organisation should also consider reporting on the effectiveness of its whistleblowing arrangements in its annual report and accounts.

Is a small caseload to be welcomed?

A low volume of concerns may have a positive or negative interpretation. It could mean that your organisation is working well and that there are no matters of concern, or it could mean that workers are afraid to speak up or don't know how to raise concerns. It is essential that your organisation has a clear policy of openness and that workers are made aware, and regularly reminded, of arrangements for raising concerns.

How do we know our whistleblowing arrangements are effective?

An open and safe workplace culture is essential for the effective working of whistleblowing arrangements. If arrangements are not seen to be working effectively, then workers will be reluctant to raise concerns and your organisation will not have the opportunity to address issues before they have potentially serious consequences. It is not enough for your organisation to have a policy and procedures in place. You also need positive assurance that your whistleblowing arrangements are working effectively.

> *"Having a good policy is only part of developing good whistleblowing arrangements. For a policy to be more than a tick-box exercise, it is vital that those at the top of the organisation take the lead on the arrangements and conduct a periodic review."*
>
> *PCaW*

The Committee on Standards in Public Life has recommended that well run organisations should review their whistleblowing arrangements, both to ensure their effectiveness and to confirm that workers have confidence in the arrangements.

Your Audit Committee should have a key role in ensuring effective whistleblowing arrangements are in place, given that such arrangements form part of the control environment of your organisation and can highlight risks to your organisation.

HM Treasury's Audit and Risk Assurance Committee Handbook suggests that part of the terms of reference for the Committee should be to "*advise the Board and Accounting Officer on.......whistleblowing processes.......*"

A range of guidance is available for audit committees on reviewing whistleblowing arrangements. Key questions include:

- Is there evidence that the board regularly considers whistleblowing procedures as part of its review of the system of internal controls?
- Is there a comprehensive record of the number and types of concerns raised, follow-up action taken and the outcomes of investigations?
- Are there issues or incidents which have otherwise come to the board's attention which they would have expected to have been raised earlier under the company's whistleblowing procedures?
- Are there adequate procedures for retaining evidence in relation to each concern?
- Have confidentiality issues been handled effectively? Have there been any failures to maintain confidentiality?
- Is there evidence of timely and constructive feedback to the worker raising the concern?
- Is there evidence of satisfactory feedback from individuals who have used the arrangements?
- Have any events come to the committee's or the board's attention that might indicate that a worker has been victimised or unfairly treated as a result of raising their concerns?
- Has there been a review of staff awareness, trust and confidence in the arrangements?
- Where appropriate, has internal audit performed any work that provides additional assurance on the effectiveness of the whistleblowing procedures?

Sources: Institute of Chartered Accountants in England and Wales Guidance for Audit Committees - Whistleblowing arrangements, March 2004
PCaW - Whistleblowing Commission Report, November 2013

Appendices

Appendix 1 - Legislation

Public Interest Disclosure legislation[6] was introduced to protect workers (see below) who wish to report a wrongdoing at work. It enables workers to make a 'protected disclosure'. **This means you can take an employer to an employment tribunal if you are discriminated against or victimised in any way as a result of making a disclosure.**

The greatest level of protection is assured if you first raise your concerns internally (see page 15) in accordance with your organisation's whistleblowing policy. This will strengthen your case at tribunal. However, you have the option to raise your concerns externally (see page 16).

What is a worker?[7]

In Public Interest Disclosure legislation, the definition of worker includes employees, contractors, trainees, agency staff, home workers, police officers and every professional in the NHS. It does not cover the genuinely self-employed (other than in the NHS), volunteers, the intelligence services or the armed forces. In addition, non-executive directors and councillors do not have protection under the legislation.

You will not be protected under Public Interest Disclosure legislation if, by raising a concern or making a disclosure, you are committing an offence.

If you have any doubts about whether you will be protected, you should seek impartial expert advice from:

Public Concern at Work
www.pcaw.org.uk
whistle@pcaw.org.uk
Tel: 020 7404 6609.

The following examples illustrate employment tribunal cases:

[6] Public Interest Disclosure Act, 1998; Public Interest Disclosure (Northern Ireland) Order, 1998
[7] Public Concern at Work guide to the Public Interest Disclosure Act , 1998

Case examples

Balmer V Church View Ltd (2002)

Miss Balmer was a young, junior member of staff in a care home who witnessed three co-workers repeatedly hit an elderly resident then refused to feed him when he complained. After reporting the incident, Miss Balmer's manager attempted to persuade her to state that she was mistaken, but she refused. Miss Balmer was dismissed for 'gross misconduct' in making a false report. The Employment Tribunal found an obvious inference in the dismissal letter that her release was 'inextricably linked to her having made the protected disclosure'. The employer failed to show that there was any investigation into the incident. The appeal hearing it conducted took no notice of Miss Balmer's grounds for appeal.

Holden V Connex SE (2002)

Mr Holden, a train driver and health and safety representative, raised concerns about public and workplace safety. After being denied sight of a risk assessment of a new rota for drivers, Mr Holden sent two reports to the Health and Safety Executive (HSE), believing there was an increased risk that signals would be passed at red. Copies were made available to colleagues. Following the Ladbroke Grove crash, a colleague told the media about the reports. Mr Holden was charged with sending an emotive and inaccurate report to the HSE. After receiving a final written warning, he resigned. The Employment Tribunal found in his favour and held that it was not necessary that all allegations in the reports to the HSE were accurate. It said that Connex paid lip-service to safety concerns and had tried to deter Mr Holden from speaking out.

Harper V Torbay Council (2006)

Mr Harper questioned the Council's tendering process for new refuse lorries and was criticised for doing so. An internal audit report found that the process was seriously deficient, but Mr Harper, who was not shown the report, was asked to sign a letter confirming that he agreed that there was no wrongdoing. Mr Harper refused and raised the issue with external auditors. He was then subjected to numerous detriments and was eventually dismissed. The Employment Tribunal found in Mr Harper's favour, citing various examples of detriment including excessive criticism, a transfer out of his department, stress, a refusal to allow him to return to work and suppression of the internal audit report. The Employment Tribunal said that from the moment Mr Harper made the disclosure, his job was in jeopardy. It also said that there had been a cover-up, a failure to manage and deception.

Source: PCaW - Where's Whistleblowing Now? 10 years of legal protection for whistleblowers

Appendix 2 - Employer Checklist

- ☐ Does your organisation have a whistleblowing policy in place?
- ☐ Is the policy supported by an open and transparent culture which encourages the raising of concerns?
- ☐ Are workers made aware of the policy?
- ☐ Is training provided on the content of the policy?
- ☐ Is there evidence of clear and explicit management commitment from the top of the organisation to an open and honest culture?
- ☐ Is there a code of conduct in place that reinforces the expectation of ethical behaviour from workers at all levels?
- ☐ Are there clear procedures and lines of reporting for workers wishing to raise concerns, perhaps using a flowchart or diagram for clarity?
- ☐ Are there clear roles and responsibilities in place for handling concerns raised?
- ☐ Does the policy offer alternative ways of raising concerns, including externally?
- ☐ Is there a specialist resource with detailed knowledge of whistleblowing who can provide advice to management and staff and be an alternative route for raising concerns?
- ☐ Is there effective awareness training for all staff so they know what concerns they can raise and how to raise them?
- ☐ Is there effective training for line managers who may have to deal with concerns?
- ☐ Is there continuing communication of your organisation's commitment to an open and ethical culture, through circulars, posters, emails and your intranet?
- ☐ Are there regular attitude surveys to determine the level of confidence staff have in arrangements for raising concerns?
- ☐ Does the whistleblowing policy make clear that your organisation will not tolerate harassment of anyone raising a genuine concern?
- ☐ Does the policy direct workers to available sources of support and advice, for example Public Concern at Work or a union?
- ☐ Are practical steps taken to protect the confidentiality of workers raising concerns?
- ☐ Do you have a plan in place should an investigation be required e.g. access to trained fraud investigators?
- ☐ Do you have adequate systems in place for recording, monitoring and reporting on whistleblowing caseload?

Appendix 3 - A Strong Policy

A National Audit Office review into Government whistleblowing policies (published January 2014) highlighted key criteria for a successful whistleblowing policy:

Commitment, clarity and tone from the top
Guidance should make clear that any concerns are welcomed and will be treated seriously. Guidance should reassure the reader who may be thinking of raising a concern that the organisation's leadership will take the concern seriously and will not punish the employee if the concern turns out to be untrue, as long as they had reasonable suspicion of wrongdoing.

Openness, confidentiality and anonymity
Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. Guidance should also outline the potential issues that could arise from employees reporting concerns anonymously.

Offering an alternative to line management
Concerns may relate to behaviours of line management, or employees may be unwilling to discuss concerns with immediate management. Alternative channels inside the organisation should be offered.

Structure
It is important that guidance is easy to use so that readers are clear about how they should raise concerns. The policy should cover all areas expected under best practice. It should be clear, concise and avoid including irrelevant detail that might confuse readers. Flow charts or similar pictorial and diagrammatic representations that outline the step-by-step process are useful techniques to support a well laid out policy.

Access to independent advice

Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should indicate where employees can seek advice, e.g. Public Concern at Work.

Whistleblowing to external bodies (prescribed persons)

Guidance should make employees aware of how they can raise concerns outside the department, e.g. to an external auditor or regulator. This is an obligation for officials in certain circumstances, for example where there is evidence of criminal activity.

Reassuring potential whistleblowers

Guidance should make clear that it is an offence for management and staff to victimise employees thinking of making a complaint. Similarly, it should make clear that employees who deliberately raise malicious and unfounded grievances will be subject to disciplinary action.

Addressing concerns and providing feedback

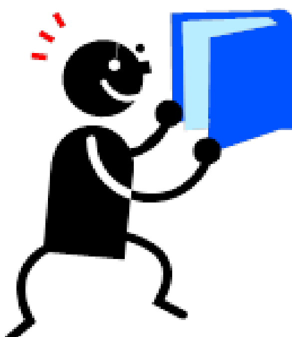
Whistleblowing policies should set out procedures for handling concerns. This should reassure employees that their concerns will be taken seriously and will ensure that instances of malpractice are identified and dealt with appropriately.

But remember, a strong policy is of little value if it is not supported by an open, transparent and supportive culture in which concerns can be raised without fear.

Appendix 4 - Sources

In compiling this Guide, we have drawn on a range of available good practice, in particular:

- PCaW: Guide to the Public Interest Disclosure Act, 1998
- PCaW: Best Practice Guide for Subscribers
- PCaW: Where's Whistleblowing Now? 10 years of legal protection for whistleblowers
- PCaW: The Whistleblowing Commission: Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK
- PCaW: FAQ Answers
- House of Commons Committee of Public Accounts: Whistleblowing, 9th Report of Session 2014-15
- Department for Business Innovation and Skills: Whistleblowing Framework Call for Evidence: Government Response, June 2014
- National Audit Office: Review into Government Whistleblowing Policies, January 2014
- Managing a Public Interest Disclosure Program: A Guide for Public Sector Organisations, 2011, published jointly by the Crime and Misconduct Commission, Queensland, Australia; Queensland Ombudsman; and Queensland Government, Public Service Commission



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Public Audit Bodies

England:
The Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
London SW1W 9SP
Tel: 020 7798 7999
Email: enquiries@nao.gsi.gov.uk
www.nao.org.uk

Scotland:
Correspondence Team
Audit Scotland
18 George Street
Edinburgh EH2 2QU
Tel: 0131 625 1500
Email: Correspondence@audit-scotland.gov.uk
www.audit-scotland.gov.uk

Wales:
PIDA Officer
The Auditor General for Wales
24 Cathedral Road
Cardiff CF11 9LJ
Tel: 01244 525980
Email: whistleblowing@wao.gov.uk
www.wao.gov.uk

Northern Ireland:
The Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast BT7 1EU
Tel: (028) 9025 1062 or (028) 9025 1000
Email: whistleblowing@niauditoffice.gov.uk
www.niauditoffice.gov.uk

Independent Advice

PCaW:
Public Concern at Work
3rd Floor, Bank Chambers
6-10 Borough High Street
London SE1 9QQ
Tel: 020 7404 6609 (helpline)
Tel: 020 3117 2520 (other enquiries)
Email: whistle@pcaw.org.uk
www.pcaw.org.uk

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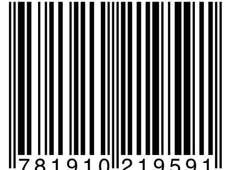

Review of the Operation of Health and Social Care Whistleblowing Arrangements

September 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

Public Concern at Work

Public Concern at Work (PCaW)[2] is an independent charity and legal advice centre. The cornerstone of the charity's work is a confidential advice line for workers who have witnessed wrongdoing, risk or malpractice in the workplace but are unsure whether or how to raise their concern. The advice line has advised over 20,000 whistleblowers to date; this unique insight into the experience of whistleblowers informs their approach to organisational policy development and campaigns for legal reform.

In February 2013, PCaW established the Whistleblowing Commission to examine the effectiveness of whistleblowing in the United Kingdom and to make recommendations for change. The Whistleblowing Commission published its report in November 2013.[3] The key recommendation of the Commission was the creation of a statutory Code of Practice, which sets out the principles for effective whistleblowing, which can be taken into account by courts and tribunals considering whistleblowing claims.

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf
[2] Public Concern at Work - http://www.pcaw.org.uk/
[3] The Whistleblowing Commission report, November 2013 - http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

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Executive Summary

Encouraging staff to raise concerns openly as part of day to day practice, is an important part of improving quality of service and providing assurance of patient safety. When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care.

This however, has not always been the case in the health service. The public inquiry into poor standards of care at the Mid Staffordshire National Health Service (NHS) Foundation Trust found that staff voices had been consistently ignored by the Trust Board. Freedom to Speak Up, the report of a review led by Sir Robert Francis was published in February 2015 and concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk.

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisations culture.

It is essential that all organisations work towards developing an open and honest reporting culture. Staff must have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately.

The findings from this review demonstrate that whistleblowing is mostly seen as a very negative term, which has not been helped by media portrayal. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There is also confusion as to what the term 'whistleblowing' actually referred to. Some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for health and social care in Northern Ireland that reflects current thinking. This should be supported by increasing the awareness for all staff about the needs and benefits of raising concerns.

A positive step in encouraging the raising of concerns would be the development of an independent helpline to provide advice and support for health and social care staff in Northern Ireland. It is recommended that this should be run as a pilot, with a subsequent evaluation to decide on whether or not to continue it.

Extremely positive steps have been taken in the area of visible leadership, but further development in this area is necessary. The review team considers that it is important to assess the effectiveness of any developments in this area.

For a system of raising concerns to work effectively, training needs to be available for staff who receive the concerns. They must be appropriately skilled in relation to managing and investigating concerns. Organisations must also assess how recording and reporting concerns fits in the overall governance process, including incident reporting and complaints

The Freedom to Speak Up report considered that feedback was an important part of the process. The review team was told that organisations generally provided feedback on action that was taken as a result of raising a concern. They considered that any method of feedback is to be supported, but feedback to individuals is essential.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. Most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

It is not acceptable for organisations to assume a low level of raising concerns is positive; they must each 'test the silence' to gain assurance that the process of raising concerns is working well in their organisation.

This report makes 11 recommendations to improve whistleblowing arrangements within HSC organisations in Northern Ireland.

Section 1 - Introduction

1.1 Introduction

Health and social care services have been developed to promote the health, wellbeing and dignity of patients and service users. The people who deliver these services generally want to do the best they can for those they serve. However, for a variety of reasons, there will be occasions when things go wrong in the workplace. Encouraging staff to raise concerns openly as part of day to day practice is an important part of improving quality of service and providing assurance of patient safety.

When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care. It is essential that all organisations should work towards development of an honest and open reporting culture, where staff have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately and properly.

The term whistleblowing has no legal definition and is not enshrined in any legislation. Originally, the term developed from British police officers (bobbies) blowing their whistles to alert the public to criminals, while later, private business owners would use their own whistles to alert the police to the fact that a crime was being committed. US civic activist Ralph Nader is said to have coined the phrase in the early 1970s to avoid the negative connotations associated with other words such as informers and snitches. However, more recent media coverage, emphasising negative outcomes for whistleblowers, has led to whistleblowing being seen as a generally negative term, which could have a detrimental effect on the way staff approach raising concerns within their organisations.

The whistleblowing charity, PCaW defines whistleblowing as “A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. regulators, media, MPs).”

Whistleblowing, or raising a concern, should be welcomed by public bodies as an important source of information that may highlight serious risks, potential fraud or corruption. Workers are often best placed to identify deficiencies and problems before any damage is done, so the importance of their role as the eyes and ears of organisations cannot be overstated.

Whistleblowing best practice and legislation[4] to protect workers raising concerns developed following a number of disasters and public scandals in the late 1980s and the early 1990s:

- capsizing of the passenger ferry the Herald of Free Enterprise (1987)
- the explosion on the Piper Alpha oil platform (1988)
- the train collision at Clapham Junction London (1988)
- the Bristol Royal Infirmary (1991-1995)

In each of these cases, workers had been aware of dangers but did not know what to do or who to approach, were too frightened to speak out due to fear of losing their jobs or being victimised, or spoke out but weren't listened to. Raising concerns or whistleblowing is therefore essential to:

- safeguard the integrity of an organisation
- safeguard employees
- safeguard the wider public
- prevent damage

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation, must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisation's culture. Workers who are prepared to speak up about wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation, by identifying and addressing problems that disadvantage or endanger other people.

The benefits of encouraging staff to report concerns include:

- identifying wrongdoing as early as possible
- exposing weak or flawed processes and procedures which make an organisation vulnerable to loss, criticism or legal action
- ensuring critical information gets to the right people who can deal with concerns
- avoiding financial loss and inefficiency
- maintaining a positive corporate reputation
- reducing the risks to the environment or the health and safety of employees or the wider community
- improving accountability
- deterring workers from engaging in improper conduct

The public inquiry into poor standards of care at the Mid Staffordshire NHS Foundation Trust[5] found that staff voices had been ignored by the Trust Board.

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[4] Public Interest Disclosure (Northern Ireland) Order 1998 - http://www.legislation.gov.uk/nisi/1998/1763/contents
[5] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - 6 February 2013 - https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Robert Francis QC concluded that:

“The board did not listen sufficiently to its patients and staff, or ensure the correction of deficiencies brought to the trust’s attention.
Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.”

In his report he went on to recommend that the:

“Reporting of incidents of concern relative to patient safety, compliance with the law and other fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.”

Dame Janet Smith in the inquiry[6] which followed the conviction of Harold Shipman, a GP who had killed at least 215 patients over a period of 24 years, commented in her report:

“To modern eyes, it seems obvious that a culture in all healthcare organisations that encourages the reporting of concerns would carry great benefits. The readiness of staff to draw attention to errors or near misses by doctors and nurses and the facility for them to do so, could have a major impact upon patient safety and upon the quality of care.”

Subsequently in her report she stated:

“I believe the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance, or health of another could make a greater contribution to patient safety than any other single factor.”

A whistleblowing commission was established in February 2013 by PCaW to examine the effectiveness of existing arrangements for workplace whistleblowing in the United Kingdom and to make recommendations for change.

The commission made 25 recommendations,[7] including a recommendation that a code of practice drafted by the commission be adopted.

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[6] The Shipman Inquiry - 27 January 2005 http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp

[7] Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK - November 2013 http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

The code of practice sets out standards to assist with development of effective arrangements for raising concerns and provides advice for organisations in relation to:

- written procedures
- training, review and oversight of arrangements for raising concerns
- dealing with anonymity and confidentiality
- legislation related to raising concerns

In November 2014, Whistleblowing in the Public Sector – a good practice guide for workers and employees[8], developed in conjunction with PCaW, was published by the four United Kingdom audit offices. It was designed to provide information for public sector workers on how to raise concerns and what they should expect in turn from their employers. It also provided guidance for public sector employers on the benefits of having a robust system for raising concerns and on how to encourage workers to raise concerns and deal effectively with those concerns.

Freedom to Speak Up[9], the report of a review led by Sir Robert Francis was published in February 2015. The review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

The review concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk. It also emphasised the importance of all who raise concerns, and those who respond to them, the need for behaving with empathy and understanding towards others, focusing together on patient safety and the public interest.

Organisations should have an ethos where genuine concerns are investigated objectively and learning shared, while supporting those who have raised the concerns. Genuine issues about an individual's performance or conduct should be dealt with separately and fairly.

The report set out a number of principles and actions under the following headings:

- culture change
- better handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- enhancing the legal protection

[8] Whistleblowing in the Public Sector - A good practice guide for workers and employers – November 2014 - http://www.niauditoffice.gov.uk/wb_good_practice_guide.pdf
[9] Freedom to Speak Up - An Independent Review into Creating an Open and Honest Reporting Culture in the NHS – February 2015 - http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

The report emphasised the need for a change in culture, with boards devoting both time and effort to achieve this change. As part of the culture change, raising concerns should be part of the routine business of any organisation and speaking up should become part of what everyone does and is encouraged to do. The report considered that policies and procedures should not distinguish between reporting incidents and making protected disclosures and that visible leadership at all levels of the organisation was essential in supporting the culture of raising concerns.

All organisations should have systems in place to support the raising of concerns both formally and informally and organisations should have a range of staff available to whom concerns may be reported. All staff should receive training in their organisation's approach to raising concerns and there should be transparency about incidents and concerns and how an organisation has responded to them.

The report also recommended that there should be an external review of systems for raising concerns, in the form of an Independent National Officer. The Care Quality Commission (CQC) was also encouraged to take account in the well-led domain of its hospital inspections, of how organisations handle concerns that are raised.

In its response to the Freedom to Speak Up review, the Scottish Government decided that:

- non-executive whistleblowing champions would be introduced in each NHS Scotland Board
- further national whistleblowing events would be provided to designated policy contacts within boards, with a view to roll out locally
- the Cabinet Secretary would write to all NHS Scotland Boards to draw attention to relevant local actions identified within the review report and ask that Health Board Chairs and Chief Executives consider how these recommendations can be implemented locally
- the Cabinet Secretary would write to Healthcare Improvement Scotland as the relevant scrutiny body in NHS Scotland, to ask it to consider and feedback on how the report's recommendation on scrutiny may be implemented

Additionally, the Scottish Government committed to: "The development and establishment of an Independent National (Whistleblowing) Officer (INO), to provide an independent and external review on the handling of whistleblowing cases".

In November 2015, a consultation paper regarding the establishment of an INO was produced by the Scottish Government[10].

[10] Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer for NHSScotland Staff - http://www.gov.scot/Publications/2015/11/5123

Regarding professional regulation, in his report, The Handling by the General Medical Council of Cases Involving Whistleblowers[11], the Right Honourable Sir Anthony Hooper noted that it is sometimes said that a whistleblower is a person who raises concerns externally, that is with persons other than his or her employer. In his opinion that was not correct. He went on to say that many people who raise concerns, do not, at the time of raising concerns see themselves as whistleblowers. They may be ignorant of the protections afforded to those who raise such concerns. They are more likely to come to regard themselves as whistleblowers if they suffer detriment as a result of raising concerns or if no action is taken in response to their concerns. The report made a number of recommendations regarding the position of raising concerns in relation to professional regulation.

1.2 Context for the Review

The Public Interest Disclosure (Northern Ireland) Order 1998[12] sets out the legislative basis for those workers who raise concerns about wrongdoing and makes provision about the kinds of disclosures that may be protected; the circumstances in which such disclosures are protected and the persons who may be protected. The Order also lists the organisations to which disclosures of information may be made under the Order.

On 17 February 2009, Circular HSS (F) 07/2009[13] provided whistleblowing guidance for HSC organisations, setting out their responsibilities and providing a model policy template for all organisations to adapt to their own circumstances. The circular stated that organisations should have clear arrangements in place to assist staff with reporting concerns. If these were not in place, organisations were to take steps to devise and implement them in line with the model policy template.

In March 2012, the then Minister for Health, Mr Edwin Poots, wrote to Chief Executives of all HSC bodies, asking them to bring the contents of his letter to the attention of all employees and make it available alongside each organisational whistleblowing policy. The letter set out a number of principles that every employee should expect in relation to raising concerns within their own organisation, which included:

- The right to whistleblow - every member of staff should be confident that managers at all levels would respond positively to expressions of concern and should it be necessary they would be protected from victimisation.

[11] The handling by the General Medical Council of cases involving whistleblowers – 19 March 2015 - www.gmc-uk.org/Hooper_review_final_60267393.pdf

[12] The Public Interest Disclosure (Northern Ireland) Order 1998 - https://www.dhsspsni.gov.uk/articles/public-interest-disclosure-northern-ireland-order-1998

[13] Circular Reference: HSS (F) 07/2009 - 17 February 2009 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2009-07.pdf

- The right to be heard by management and a responsibility to speak up – staff should feel empowered to speak up if they see, or become aware of practice which is unsafe, or creates unacceptable risks to patients or clients. Managers and leaders at all levels would then be responsible for creating and maintaining an atmosphere of mutual support and mutual learning.

The letter concluded with encouragement for staff to raise genuine concerns where appropriate and emphasised that this was a vital element of good public service based on the values and principles that are at the heart of Health and Social Care.

In December 2014, the then Department of Health, Social Services and Public Safety (DHSSPS) commissioned Sir Liam Donaldson to carry out a review of the arrangements for assuring and improving the quality and safety of care in Northern Ireland. His report, The Right Time the Right Place[14], made a number of recommendations including that "the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the minister".

In August 2015, Dr Paddy Woods, Deputy Chief Medical Officer, commissioned RQIA to undertake a review of the operation of HSC whistleblowing arrangements.

This review forms part of the Department of Health's (DoH) overall review of HSC whistleblowing arrangements.

The report makes 11 recommendations in order to continue the journey towards normalisation of raising of concerns within HSC organisations in Northern Ireland.

1.3 Terms of Reference

The terms of reference for this review were:

1. The review will consider the:
    a. existence (current, consistent, robust)
    b. operation (understanding, training, learning)
    c. accessibility, availability, support
    d. governance

   of Arm's Length Bodies' whistleblowing arrangements.

2. In light of the findings of the review RQIA will identify any recommendations for improvement to the arrangements.

[14] The Right Time the Right Place - An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland – December 2014 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf

1.4 Exclusions

The review has excluded the whistleblowing arrangements within the Northern Ireland Fire and Rescue Service and RQIA.
The Northern Ireland Guardian Ad Litem Agency has also been excluded from the review. These organisations will be assessed by the DoH[15] at a later stage.

Circulars, guidance, standards, reviews and reports which arise during the course of this review will not be assessed as part of this review and will be highlighted for consideration in the future.

1.5 Review Methodology and Scope

The scope of the review included the following organisations:

DoH – Arm's Length Bodies *	
Belfast Health and Social Care Trust	Patient and Client Council
South Eastern Health and Social Care Trust	Business Services Organisation
Northern Health and Social Care Trust	Northern Ireland Blood Transfusion Service
Southern Health and Social Care Trust	Public Health Agency
Western Health and Social Care Trust	Northern Ireland Medical and Dental Training Agency
Northern Ireland Ambulance Service Health and Social Care Trust	Northern Ireland Practice & Education Council for Nursing and Midwifery
Health and Social Care Board	Norther Ireland Social Care Council

PCaW, a whistleblowing charity, is accepted as a leading authority in this field. They:

- advise individuals with whistleblowing dilemmas at work
- support organisations with their whistleblowing arrangements
- inform public policy and seek legislative change

[15] On 9 May 2016, as part of the restructuring of the Northern Ireland government departments, Department of Health, Social Services and Public Safety has been renamed the Department of Health.

RQIA engaged PCaW to assist with a number of pieces of work to inform the review.
The review included the following stages, designed to gather information about the presence and operation of HSC whistleblowing arrangements:

- A review of relevant literature set out the context for the review and identified appropriate lines of enquiry.

- Meetings with professional regulatory and representative organisations to obtain their views about whistleblowing arrangements, to help inform the review.

- A review of each organisation's whistleblowing policy and procedures against best practice guidance.

- Staff engagement and obtaining their views was a key element of this review. A staff questionnaire was developed and distributed to staff in the organisations subject to the review. Secondly, RQIA worked in partnership with PCaW to hold focus groups with a range of staff groups in each of the organisations.

- Information was obtained from the HSC staff survey which included a number of questions about whistleblowing arrangements.

- Validation visits to each of the organisations were undertaken, to meet with staff who have responsibility for the operation of whistleblowing arrangements and other senior staff including board members.

- A stakeholder event to present the initial findings from the review to representatives from each of the organisations. The majority of organisations involved in the review were represented, with 40 delegates attending the event. The findings from the review were discussed, and delegates made suggestions for enhancing and taking forward the recommendations from the review.

Findings from questionnaires, meetings with organisations and feedback from the stakeholder event were collated, and the information used to inform this report. The report is an overview report and provides a regional view of arrangements for raising concerns and provides general recommendations to improve the process for raising concerns in Northern Ireland. No organisation is reported individually.

Section 2 - Findings from the Review

2.1 Engagement with Interested Stakeholders

During the planning stages of the review, RQIA met with several professional regulatory and representative organisations, including the General Medical Council[16], the Pharmaceutical Society of Northern Ireland[17], the Royal College of Nursing[18], the Chair of the Trade Union Forum, UNITE[19], and UNISON[20]. The meetings were designed to obtain their views about current whistleblowing arrangements within health and social care, with the intention of using the information to inform the review.

Professional Regulatory Organisations

The General Medical Council and the Pharmaceutical Society of Northern Ireland are the professional regulatory organisation for doctors and pharmacists respectively. They have legal powers to set guidance, and have done so in relation to the raising of patient safety concerns and in the professional duty of candour.

Both organisations have guidance[21,22] in relation to raising concerns, which places a duty on the professionals they regulate to raise concerns where they believe that patient safety has been compromised. They also state that professionals must be open and honest with their regulators, and with each other to ensure that concerns are raised where appropriate.

Both regulators provided advice and support to members who were considering raising a concern or had already done so. They generally did not raise a concern on behalf of a member, but supported them to raise their concern through the mechanisms within their own organisation.

Unions

Not all Unions representing workers in health and social care engaged with RQIA during the review. The Royal College of Nursing, UNITE and UNISON did take the time to engage.

The Unions represent the professional interests of staff working in a range of health and social care specialties and settings.

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[16] General Medical Council - http://www.gmc-uk.org/
[17] Pharmaceutical Society of Northern Ireland - http://www.psni.org.uk/
[18] Royal College of Nursing - https://www.rcn.org.uk/
[19] UNITE - http://www.unitetheunion.org/
[20] UNISON - https://www.unison.org.uk/
[21] General Medial Council guidance on whistleblowing - http://www.gmc-uk.org/DC5900_Whistleblowing_guidance.pdf_57107304.pdf
[22] Pharmaceutical Society of Northern Ireland guidance on whistleblowing - http://www.psni.org.uk/wp-content/uploads/2012/09/Guidance-on-Raising-Concerns.pdf

They provide advice and support to members who were considering raising a concern or had already done so, but generally did not raise a concern on their behalf. They encourage their members to raise concerns through mechanisms already in place within their own organisation.

All Unions provide guidance[23,24,25] on whistleblowing for their members. During discussions, Unions were able to cite many examples where staff were afraid or unwilling to raise concerns.

Outcome of the Discussions

The outcome of these discussions was consistent with the themes that were uncovered during the review. In summary all organisations considered:

- the term whistleblowing as being negative and not conducive to encouraging staff to raise concerns
- the current arrangements were not suitable and many cases were not managed appropriately
- there was a lack of awareness and training in relation to whistleblowing

All organisations welcomed any improvements to the arrangements for raising concerns. They expressed a willingness to be involved in the development of new arrangements, as well as becoming a more integrated part of these new arrangements.

2.2 Review of Whistleblowing Policies

In the initial stage of the review, all HSC organisations were asked to submit their whistleblowing policies. In order to review these documents, PCaW adopted the methodology used by the United Kingdom National Audit Office (NAO), following their review of a number of United Kingdom government departmental and Arm's Length Bodies' whistleblowing policies in 2014. This methodology was devised following wide consultation by the NAO, and closely follows the requirements on best practice for whistleblowing arrangements, encapsulated in the Whistleblowing Commission's Code of Practice[26] and the British Standards Institution's whistleblowing guidance.[27]

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[23] Royal College of Nursing guidance on whistleblowing - https://www.rcn.org.uk/employment-and-pay/raising-concerns/guidance-for-rcn-members
[24] UNITE guidance on whistleblowing - http://wbhelpline.org.uk/resources/raising-concerns-at-work/?doing_wp_cron=1395055349.5939080715179443359375
[25] UNISON guidance on whistleblowing - https://www.unison.org.uk/get-help/knowledge/disputes-grievances/whistleblowing/
[26] The Whistleblowing Commission was established by PCaW in early 2013. The Independent Commissioners took evidence from stakeholders in whistleblowing and published a report in November 2013 that included a proposed Code of Practice, which forms the basis of PCaW's best practice guidelines. Copies of the full Commission report, including the Code of Practice are available on http://www.pcaw.co.uk/
[27] BSI publicly available specification 1998:2008 http://shop.bsigroup.com/forms/PASs/PAS-1998/

Each organisation's whistleblowing policy was assessed against eight criteria, which are based on good practice and current whistleblowing legislation. The NAO review criteria[28] are summarised below. While each policy has been reviewed against the detailed criteria, this report contains general trend analysis and a summary of main findings. The categories for review adopted by the NAO and used to assess the policies reviewed for this report are:

Setting a Positive Environment for a Whistleblowing Policy

a. **Commitment, clarity and tone from the top**
This involves making it clear to staff that any concern will be welcomed; it should reassure the reader, who may be thinking of raising a concern that the organisation's leadership will take it seriously and will not punish the employee if the concern turns out to be untrue, as long as the employee had reasonable suspicion of wrongdoing.

b. **Structure**
It is also important that guidance is easy to use so that readers are clear how they should raise a concern. The policy should include information relating to all areas of whistleblowing and provide comprehensive guidance for employees. It should be clear, concise and avoid including irrelevant detail that might confuse readers.

c. **Offering an alternative to line management**
Concerns may relate to behaviour of line managers or an employee may be unwilling or unable to discuss concerns with immediate management. Thus, alternative channels inside the organisation should be offered. Staff may be unwilling to approach extremely senior people with a concern, so the alternatives offered should be suitable.

d. **Reassuring potential whistleblowers**
Guidance should make clear that it is serious misconduct to victimise employees who are preparing to raise a concern, or have already done so. Similarly, it should make clear that employees who knowingly disclose false information will be subject to disciplinary action.

e. **Addressing concerns and providing feedback**
Whistleblowing policies should set out procedures for handling concerns. This will reassure readers that their concern will be taken seriously and also that wrongdoing can be identified and dealt with appropriately. The organisation should be clear about the actions it will take to investigate the concern and the feedback it will be able to provide to whistleblowers. Best practice will also give a general indication of the timescales involved in handling concerns, e.g. how long it will take to arrange an initial meeting, provide feedback etc.

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[28] National Audit Office – Assessment criteria for whistleblowing policies – January 2014 - https://www.nao.org.uk/wp-content/uploads/2014/01/Assessment-criteria-for-whistleblowing-policies.pdf

Supporting Whistleblowers

a. **Openness, confidentiality and anonymity**
Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. It should also outline the potential issues that could arise from employees reporting a concern anonymously.

b. **Access to independent advice**
Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should address the point and identify how to contact potential advisers.

c. **Options for whistleblowing to external bodies (prescribed persons)**
Guidance should make employees aware of how they can raise a concern outside the organisation, e.g. to an external auditor or regulator. This may be a legal obligation in certain circumstances, for example where there is evidence of a criminal act. Guidance that follows best practice should encourage internal reporting, as this is where the concern can be addressed most effectively and where employees will receive the greatest protection. However, guidance should also identify the procedure for external reporting as well as outline potential bodies that employees can raise a concern with.

Assessment of Whistleblowing Policies

With these criteria in mind, an overall assessment is now provided of the organisations' policies as a whole against each of the above criteria, commenting on common trends and gaps in the policy wording overall.

a. Commitment, clarity and tone from the top
In order to achieve an excellent rating: there should be a stated commitment to maintaining high ethical standards and taking concerns seriously; the language should be inviting and reassuring; and there should be a clear distinction between whistleblowing and other concerns or grievances. Only a small number of the policies (two out of 14) scored an excellent rating in this category.

As a general rule, there was a lack of evidence of senior leadership contained in the policies reviewed. While many of the policies referred to a commitment on the part of the organisation to ensure that the policy and accompanying processes work in practice, rarely did this specifically refer to the leadership of the organisation. This is essential if the policy aims to instil trust and confidence in the process for all staff.

While in many of the policies reviewed, there was language stating that the organisation was committed to operating at very high standards, rarely was a specific body (such as the organisational board or equivalent) referred to.

Many of the policies referred to the Public Interest Disclosure Order as the starting point for the introduction to the policy or as the reason for having the policy. If the aim of the policy is to encourage staff to speak up and to ensure that it is safe and acceptable to do so, then this will not set the right tone from the start. In this category, two policies were rated as excellent, eight as satisfactory and four as poor.

b. **Structure**
An excellent rating in this category required the policy to be concise and well-presented, provide clear guidance that is both factual and informative, and guide the reader through the process in easy to follow language (flowcharts are recommended).

A third of the policies reviewed achieved an excellent rating in this category. One of the problems with many of the policies reviewed was a legalistic approach to the policy wording (i.e. leading with the Public Interest Disclosure Order as the introductory wording). Using the language of complaints and grievances and or/mixing management guidance for handling a concern were also issues with a number of the policies scrutinised.

An impersonal approach with a focus on an individual's responsibilities as opposed to focusing on the organisation's commitment to protect those raising a concern or disclosing information, would also have resulted in a low score for this category. Of the 14 policies, four were rated excellent, six satisfactory and four poor in this category.

c. Alternative to line management
Suggesting that workers consider raising a concern with their manager, but at the same time offering alternatives to the line management are both essential for any whistleblowing policy to be effective. It is clearly important that the line management process is included in the 'how to' section of any whistleblowing policy, as this will often be the starting point for raising a concern for most workers. However, it is also vital that any policy includes an alternative to line management, as the concern may relate to the behaviour of the line manager or it may be that line management is involved in the wrongdoing.

To gain an excellent rating, the policy should consider inclusion of appropriate contacts for the types of concerns being raised, have a flexible approach to when a concern might be raised outside of the management line and provide name and contact details for those designated to receive concerns. A number of the policies required individuals to raise the issue with their line manager first; this would have resulted in a low score because although it is proper to go through line management it should never be an absolute requirement. Six policies scored highly in this category, five were satisfactory and three were rated as poor.

d. **Reassuring potential whistleblowers**
An excellent policy will include language to assure the individual that they will not face sanctions for honestly raising a genuine concern, irrespective of whether they later turn out to be wrong. It will confirm that there are sanctions for victimising those who raise a concern or for preventing a concern being raised, and will also confirm that it is an abuse of the policy, and therefore a disciplinary offence, to knowingly raise a false concern.

Only one policy scored an excellent rating in this category. The main reason why many policies received a low score was the fact that disciplinary sanction was applied to frivolous/malicious/vexatious concerns. In order to strike the right balance, policy wording should only apply sanctions to the knowingly false concern. Extending sanctions more broadly, risks adding to the already numerous hurdles that whistleblower's experience, without necessarily reducing the number of concerns raised which lack merit.

e. **Addressing concerns and providing feedback**
In order to score highly, the policy wording should reassure readers that their concern will be taken seriously and also that wrongdoing will be identified and dealt with appropriately. It should include a summary of the procedures for handling concerns, an indication of how long before feedback is provided (noting that this will depend on the nature of the concern), an outline of the type of feedback whistleblowers can expect (while respecting the confidentiality of those being investigated), and clear guidance to managers on how to handle concerns (which may be published as a separate document[29]).

In this category, five policies scored highly, six satisfactory and three were rated as poor. Examples of difficulties in the policies reviewed include a lack of clarity around timescales (or no mention of this at all), using the language of a grievance process, requiring written statements from those using the policy, and long detailed manager's guidance which could confuse the concerned member of staff wishing to use the policy.

f. Openness, confidentiality and anonymity
An excellent rating clearly explains the difference between anonymity and confidentiality, and outlines where confidentiality cannot be maintained (e.g. where legal obligations mean that the identity of the person providing the information will have to be disclosed). It will encourage open disclosure and outline the difficulties with raising a concern anonymously (namely difficulties investigating, providing feedback, and protecting an individual's identity). The NAO review also requires a statement that anonymous disclosures are preferable to silence about wrongdoing.

[29] Public Concern at Work would suggest that this should be published as a separate document in order to keep the messaging in the policy itself as clearly aimed at those considering raising a concern.

It might also be sensible to say that anonymous concerns will be investigated in any event, but that there may be limitations on the protection available if the identity of the person raising the concern is unknown.

Difficulties with the wording of policies reviewed, included reference to the duty of confidentiality being more important than anything else, in terms of how the individual approached the raising of concerns and/or limited assurances around the protection of the individual's identity. In the latter case, the most common problem identified was that the policy stated that the organisation will use 'all reasonable steps' (or similar wording) to protect identity rather than confirming that if asked, the individual's identity will not be disclosed unless required by law. Other common issues with this category included use of confusing language about data protection, and patient confidentiality being referred to, at the same time as explaining the key policy assurance around the worker's identity. Four of the policies scored highly in this category, nine had a satisfactory rating and one had a poor rating.

g. Access to independent advice
To score highly here, a policy will address how an individual can obtain independent advice, and list relevant bodies, such as, PCaW, trade unions and professional associations, along with their contact details. The majority of the policies reviewed contained information about advice services including PCaW. In this category, 12 policies scored an excellent rating, and three satisfactory. The latter rating was applicable where only one source of external advice is referred to.

h. Options for whistleblowing to external bodies (prescribed persons)
An excellent rating will be achieved by policies which include external sources for raising a concern, including a comprehensive list of regulatory and oversight bodies relevant to the organisations and discussion on wider disclosures and the risks involved. The majority of the policies reviewed included reference to external bodies, but surprisingly many did not refer to the relevant healthcare regulators for Northern Ireland, RQIA and the Northern Ireland Social Care Council (NISCC), as organisations prescribed in the Public Interest Disclosure Order to which a protected disclosure may be made. Eleven policies scored an excellent rating in this category and four were satisfactory (usually because key regulators were not mentioned).

2.3 Staff Surveys

During the planning stage of the review, trust representatives reported that a staff survey specifically in relation to whistleblowing arrangements had been carried out in the Southern Health and Social Care Trust (Southern Trust). A decision was taken to carry out a similar survey in the other Arm's Length Bodies, as part of the RQIA review.

Subsequently, a questionnaire was issued to all staff from Arm's Length Bodies, via Survey Monkey, based on the Southern Trust questionnaire. The process was not repeated in the Southern Trust, as they had agreed to allow their results to be included in the final report. The regional HSC survey, which contained a number of questions related to whistleblowing, had just been conducted prior to the RQIA review.

3085 staff completed the RQIA questionnaire and a breakdown of numbers per organisation[30] is shown in the Table 1 below.

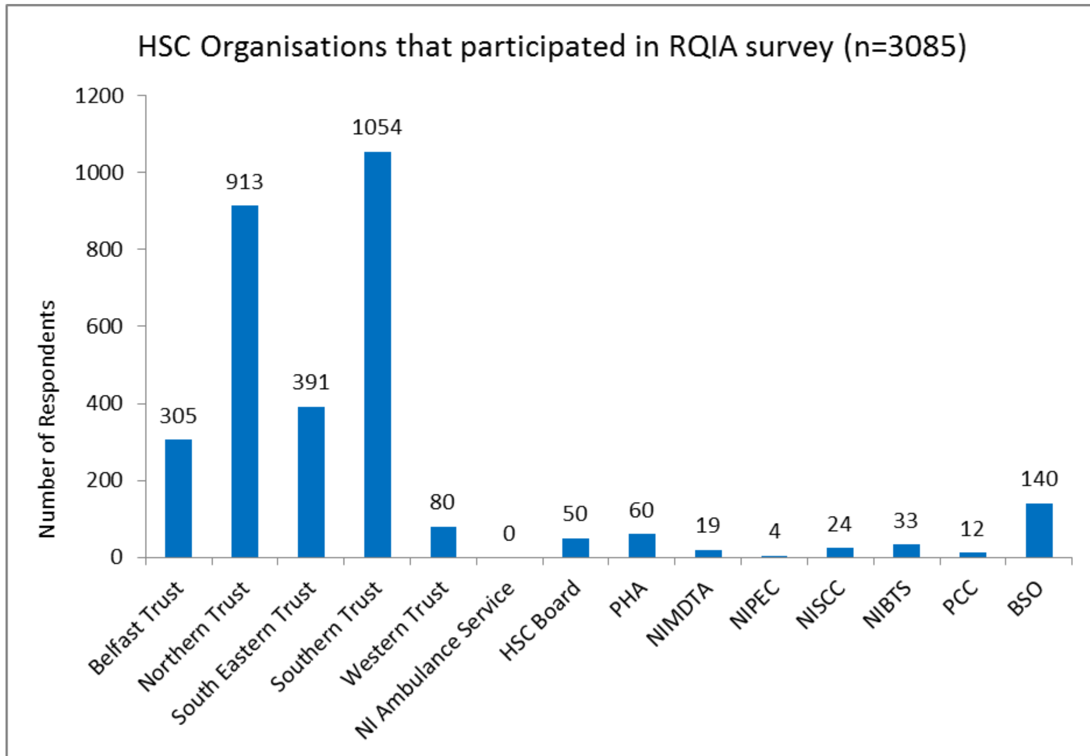

Table 1 – Number of responses per organisation

The RQIA questionnaire asked a number of questions that were similar to those asked by the regional HSC survey; however, the RQIA questionnaire allowed staff to enter freetext in order to explain the reasons, if any, as to why they had given a particular answer.

2559 (82.9%) respondents were aware that their organisation had a whistleblowing policy in place that provided guidance on how to raise a concern. However, only 1709 (55.4%) had confidence that their organisation would carry out a robust investigation of any concern they might raise.

Staff were asked if they would feel comfortable raising a concern with a senior manager/director in their organisation.

[30] It was reported by the Northern Ireland Ambulance Service that due to an administrative oversight, the survey was not distributed to their staff.

1632 (52.5%) answered yes to this question. A number of reasons were given as to why those who answered no would not feel comfortable. A summary of these responses included:

- afraid of the consequences
- afraid of repercussions
- afraid to be seen/labelled as a trouble maker
- afraid of harassment, victimisation and bullying
- fear of intimidation
- fear of reprisal
- fear of being isolated
- fear of losing job
- impact on career development and promotion
- lack of support and protection
- lack of confidentiality
- concerns were ignored
- raised concern before and it was ignored
- seen how cases were handled in the past
- don't have confidence in the process or management to deal with the concern appropriately

1553 (50.34%) respondents felt they would be more likely to raise a concern using a web based system that guaranteed anonymity.

841 (27.3%) respondents had experience of raising a concern within their organisation. The majority of those (681) had raised the concern with their line manager. 572 (68%) had not referred to the organisation's whistleblowing policy and the majority 745 (88.6%) had not raised the concern anonymously.

477 (56.7%) of those who had raised a concern felt that the concern had not been dealt with appropriately. The reasons given by respondents as to why they felt their concern had not been dealt with appropriately were:

- concern was ignored or not investigated
- poor investigation
- the concern was covered up
- the issue was put on hold, but never revisited
- got punished for raising the concern
- nothing happened/changed, and the issue persists
- issues still ongoing
- never got any feedback
- don't know the outcome

Of the 841 staff who had raised a concern, 372 (44.2%) considered that they had suffered detriment as a result of raising that concern. The key areas where staff believe they suffered detriment as a result of raising a concern:

- no action was taken and the person continues to do what they were doing
- person got moved or was transferred after raising concern

- disciplined for raising concern
- career has suffered - got overlooked for jobs and promotion
- financially worse off - fighting the case, impact on salary and pension
- damage to reputation
- was isolated/ignored by colleagues
- got bullied at work
- suffered from stress
- victimised after raising concern
- health has suffered - emotionally and physically

However, the majority – 627 (74.6%) reported that they would be very likely or likely to again raise a concern if they suspected wrondoing which is a positive result, showing that staff understand the importance of raising concerns.

Staff were also asked a number of questions specifically regarding fraud. The vast majority were aware that fraud falls within the scope of whistleblowing, were aware of a fraud policy within their organisation and would feel comfortable raising a concern regarding fraud with a senior manager/director within their organisation**.**

Finally staff were asked what would have improved the experience for them. The key points staff rasied were:

- a dedicated liaison person as a contact
- support from management
- counselling and support
- being listened to
- professional respect
- confidentiality
- the concerns being taken seriously
- formal process
- assurance that something will get done/ investigated
- having the whole process completed quicker
- a robust investigation
- a more open and transparent process
- appropriate action
- honesty from people involved
- feedback on the outcome
- a fair outcome

A regional staff survey was conducted in all HSC organisations in Northern Ireland from October to December 2015. This was conducted prior to the RQIA review and its questionnaire contained a number of questions regarding whistleblowing/raising concerns. The relevant questions were as follows:

- Are you aware of your organisation's policy and process for raising concerns about negligence or wrongdoing?
- Would you have the confidence to speak up within your organisation and raise concerns if you had cause to do so?

- Do you have confidence that your organisation would appropriately handle the investigation of any concerns raised?
- Are you aware of your organisation's whistleblowing process?
- Do you understand your responsibility under your organisation's whistleblowing process?

All organisations surveyed a full census of staff, with sample sizes ranging from 19 to 22,567. The overall number of staff surveyed was 70,213. 17,798 completed questionnaires were returned from this sample, which is a response rate of 26%. The key results from the regional survey were:

- 88% of staff reported that they are aware of their organisation's policy and process for raising concerns about negligence or wrongdoing
- 80% of staff reported that they would be confident to speak up and raise concerns if they had cause to
- 65% of staff reported that their organisation would appropriately handle the investigation that resulted
- 81% of staff reported that they are aware of their organisation's whistleblowing process
- 79% of staff reported that they understood their responsibility under their organisation's whistleblowing policy

Although the results from the HSC survey presented a positive reflection of whistleblowing, the review team was concerned that 35% of staff who responded were not confident that their organisation would appropriately handle the investigation of any concerns raised.

2.4 Focus Groups

As part of the review, staff were engaged in a series of focus groups and one-to-one appointments across all of the organisations involved in the review. The aim of these sessions was to determine staff perception and knowledge of, as well as trust and confidence in, their respective organisation's whistleblowing arrangements.

PCaW was commissioned to undertake this part of the review, in conjunction with RQIA staff. It was considered that as an organisation, they brought the necessary expertise, as their advice line has advised over 20,000 whistleblowers to date. This gives them a unique insight into the problems workers regularly face, when trying to raise a whistleblowing concern and when seeking action in relation to the issue raised. It was also considered that staff might raise a concern with them more readily than they would with RQIA alone.

Methodology

Over a four week period, 13 organisations were involved in the focus groups, with 368 individuals from a cross section of different staff groups participating in sessions.

This is a small number compared to the total number of staff working in health and social care. However, the review teams consider that the feedback provided a fair representation of staff understanding of the existence, operation and accessibility of whistleblowing arrangements across the sector.

Due to the size of the task (60,000 staff across the 14 organisations), it was not practical for PCaW to meet with every organisation. For several of the smaller Arm's Length Bodies, focus groups were undertaken solely by representatives from RQIA. For the larger Arm's Length Bodies, such as the trusts, PCaW facilitated the focus groups with RQIA in attendance. Within the trusts, focus group sessions were held at several locations. Following a low turn-out at one of the health trusts visited, repeat sessions were again undertaken solely by RQIA staff.

All focus group sessions were structured around a series of basic questions, intended to elicit discussion and thought on the broad themes of the engagement, i.e. perception, understanding, trust and confidence. However, these questions were only the starting point for an informal group discussion, and in most instances the conversation took unique, interesting and sometimes disparate turns. Nevertheless, across sessions, several consistent and strong themes emerged and these are detailed in the body of this report.

In addition to the focus groups, at each site an opportunity was provided for those with experience of whistleblowing to speak to PCaW staff. These experiences have been referenced where appropriate in the main body of this report, but also form the content of Appendix 3, where a number of anonymised case studies focusing on the experience of those involved have been included. A number of case studies were excluded, as individuals were seeking ongoing advice about their particular circumstances and the sensitive nature of such cases prevents inclusion of even an anonymised version of events. The inclusion of the case studies in Appendix 3 were discussed with those involved, and their permission was granted for inclusion in this report.

During the focus group sessions, all staff who attended were asked to write down suggestions on how whistleblowing arrangements could be improved. These suggestions have been collated and are set out in Appendix 2.

Themes and Perceptions

The almost universal perception was that the term whistleblowing was viewed as being a negative label for the process of raising a concern.

The terms 'touting', 'squealing' and 'telling tales' were regularly cited as being linked to the term 'whistleblowing' and for many, these appeared to be inextricably linked to the history of the Troubles in Northern Ireland. Indeed, this theme, while not always explicitly expressed, seemed to touch upon various aspects of the general discussion around whistleblowing. From an outside perspective, this period in Northern Ireland's history seemed to permeate a culture of silence from community level through to the workplace with respect to questioning wrongdoing.

It should be noted, that in no sessions did the question of religious or political affiliation get raised; the relevant issue appeared to be how you were seen to interact with authority in a generalised sense.

It was notable that there was a clear trend with younger workers, who may have been less influenced by this political history, to have slightly more positive views surrounding the issue. Several of this group made comments to the effect that they believed their peers saw whistleblowing/raising concerns for what it was; a necessary ingredient in carrying out your job. Clinicians (especially representatives from nursing and pharmacy) were on the whole, more positive in relation to raising concerns, and a large part of this seemed to be from recent pushes towards a more ‘open and honest culture’ within their teams. This also appeared to be closely linked to the incident reporting and quality improvement agenda in several of the organisations involved. It was identified that in the medical records and pharmacy departments, which were often held accountable for issues, such as, missing charts or wrong prescriptions, staff had a clearer understanding of the need and process for raising concerns.

There was, however, an interesting nuance to these views. While there was almost universal agreement that whistleblowing was seen negatively, only a small proportion of participants were prepared to ascribe those views to themselves. In other words, they saw whistleblowing as ‘doing the right thing’, but believed others would see it in a negative light and too often the individual will be seen to be part of the problem. Perhaps this is in part because individuals may have felt uncomfortable expressing a view they felt would paint them in a negative light (i.e. not doing anything about a serious issue they had witnessed). It was also possible that those who attended sessions may not have been a fully representative subset of the work force. Nevertheless, it seemed that there was a clear disjoint between how whistleblowers were actually seen and how they were perceived to be seen.

There was a strong view that the act of whistleblowing resulted in negative consequences for the whistleblower.

The most prevalent negative outcome discussed was that of blacklisting, or general stalling of career prospects. Many participants seemed resigned to the fact that this was in many ways a natural and expected outcome of becoming known as a whistleblower. Equally, however, there was also a fear of retribution, although in many instances it was assumed that this would come from colleagues more than management. In one group, a threat to physical safety to both the individual and their family was discussed; however, this was very much a fringe view.

In several sessions, it was commented on how this fearful view was to a large degree driven by the media’s portrayal of whistleblowers’ fortunes. Participants referenced how the only stories published were those where the whistleblower had suffered personally and that this in turn built an image that all whistleblowing ended negatively.

In fact, as most participants had no personal or direct experience of whistleblowing, it may well be that the only factor currently driving such a perception of negative outcomes is the media. Where individuals had been involved in whistleblowing (see Appendix 3), the overriding experience was negative, whether as the individual who had reported an issue, or as an accused. There were, however, a small number of participants who had been involved in the investigation or oversight of the whistleblowing process and these individuals had more positive views and better overall understanding of the process.

Understanding of the term 'whistleblowing' was inconsistent, confused and in many cases, wrong.

One of the strongest themes to emerge from the sessions was the almost universal confusion as to what the term 'whistleblowing' referred to. Almost all participants understood it to be some form of raising concerns but the 'how/where/what' varied hugely. There were almost as many variations and combinations as there were groups; however, certain common factors were consistently mentioned during the discussions.

Many participants considered that whistleblowing was only used if the issue being raised was very serious. Others considered that it was when the concern was being raised outside of the organisation (perhaps to the media), and some believed it was when the concern was raised anonymously. A less widespread but still prevalent understanding was that whistleblowing referred to those incidents of reporting which were likely to result in a specific individual being put under scrutiny. Additionally, another common view was that whistleblowing was an option of last resort; a means of raising concerns when all other routes had been tried. Many staff thought that the starting point for whistleblowing would be with a line manager. When asked, very few individuals knew what was in their organisation's policy itself and only one participant had received specific training.

This lack of conviction in what whistleblowing might refer to manifested itself sharply in participants' conception of how whistleblowing fitted in with existing reporting procedures, which is to say what circumstances required whistleblowing as opposed to recording on Datix[31] or serious adverse incident reports[32]. This was of particular interest given that, while most individuals had difficulty differentiating between reporting streams, whistleblowing was seen negatively whereas everything else was just part of the job. This felt like a very significant area of confusion for the participants. Most staff were unable to conceptualise when or how a whistleblowing policy might be invoked.

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[31] Datix is the leading supplier of patient safety software for healthcare risk management, incident and adverse event reporting. The software is widely used within both public and private healthcare organisations around the world. - http://www.datix.co.uk/

[32] This sort of confusion was less prevalent in those participants based in non-clinical environments given that they very rarely used the clinical reporting lines. That being said, generally understanding of whistleblowing was actually better in clinical groups as opposed to non-clinical.

Another common, although less pervasive area of confusion, was the difference between grievances and whistleblowing. Even those participants, who claimed to have a better understanding of the distinction, on further discussion, rarely had any confidence in their assertions.

Although there is no specific and universal definition of the term whistleblowing, especially in a complex medical environment where it must interact with multiple other reporting streams, what is important is a degree of consistency in understanding across the workforce. When this misunderstanding of the term is combined with the background of historic influences and the sense of potential negative outcomes, it seems that for the most part, staff would not consider using a whistleblowing process.

It was the view of many of the staff groups that whistleblowing was often seen as a process intended as a safety net for when the usual reporting systems do not work. Without more effort in the communication process, it would seem that there is a dangerous tendency towards a culture of silence. This was despite the view that to report risk or wrongdoing was the right thing to do. This may present a risk that where existing reporting structures do not capture a concern, it may be lost and harm to patients may potentially ensue.

Throughout the sessions, a popular suggestion was to do away with the term 'whistleblowing' given both the confusion and negativity that surrounds it. Unfortunately language does not work like this, and removing a word from internal publications will not stop the public and the media continuing to use it. The risk here is that you entrench negative views towards some of the rarer, but often entirely appropriate, ways of raising concerns. Some participants saw the value in incorporating whistleblowing into the wider family of raising concerns rather than not using it at all.

Some of the group discussions centred on the perception that one of the barriers to raising concerns might be that the issue raised would not be addressed. This results in a sense of futility, therefore discouraging the individual from raising a concern in the first place. There were mixed views expressed around this theme. In many of the discussions about raising an issue with an immediate line manager, there was a sense that the issue would be addressed; however, it was less clear that raising the issue further up the line management chain would be as easy. In a minority of the discussions, the difficulties and problems surrounding other reporting mechanisms, such as Datix, and confusion where raising concerns fits within the system, were mentioned as a more fundamental problem with safety reporting mechanisms in the health service generally.

Knowledge

Although rarely explicitly stated, it was clear that whistleblowing policies were misunderstood and a lack of knowledge about the content of such polices was almost universal.

Almost all participants knew that their trust had a whistleblowing policy and the vast majority could find it if needed. However, very few participants had actually ever read it, knew the content of it, or understood it.

This appeared to be part of a wider trend with respect to policies. A consistent message was that the overbearing number of policies made it impractical to read them all and so policies were only accessed when they were needed. For the majority of participants, this was a satisfactory state of events; however, several groups recognised that this approach presented a problem if the policy was intended to convey messages relevant at a point before things had gone wrong.

Of those that had read the policy, all but a negligibly small number belonged to the following groups:

- their job role meant they had frequent contact with policies
- they had been in a situation in which they believed the policy applied
- they had read it in preparation for the focus group

Of those that had not seen the policy, there was usually little idea of what it might contain. Commonly, it was suggested that the policy allowed a worker to contact someone higher in the line management chain where their concerns had not been dealt with by direct management. Some participants suggested that the policy might contain a list of individuals who could be approached with concerns, although there was generally little idea how this might extend outside of the line management chain.

Where a policy only fulfils its function when actively sought out by workers, it naturally follows that it does not serve that function if individuals are unaware of when it might be relevant to their situation. This is obviously the case with respect to the widespread confusion as to what whistleblowing refers to (see above) but also relevant where there is little conception of what the policy might contain. Most of the organisations' policies contain commitments about protection of whistleblowers, options for raising concerns outside of line management and assurances that their concerns will be properly investigated. These messages will be of no use to staff who make their decisions not to access the policy because they are: scared of the consequences; do not consider their line manager an appropriate contact; and do not believe their views will be valued.

It is of note that only one individual advised of receiving any training on the issue of whistleblowing. This was provided by the Royal College of Nursing as part of an external training resource, as opposed to being part of any in-house training module.

Outside of the line management chain, where experiences were generally positive, knowledge of other forums for raising concerns was sparse.

Most participants mentioned their line manager as the natural starting point for raising a concern they may have. Several groups touched upon the challenge involved in escalating an issue to the line manager's line manager. This was seen to be problematic as the senior manager may well have a personal relationship with the line manager. Indeed, multiple participants told us of circumstances where an issue that had been escalated had been passed straight back down to the line manager, rendering the escalation beyond the line manager not only pointless, but also problematic and potentially confrontational. When asked, several line managers involved in the focus groups had negative attitudes toward the concept of being circumvented by those staff members they manage. Lack of knowledge of the routes open to staff through whistleblowing arrangements was as prevalent among managers as it was with those with no management responsibilities.

Most commonly, staff referred to Human Resources (HR) as an alternative to the management line. A point of contact in Risk and Governance was also suggested, and when put forward as an alternative; some participants saw value in this idea. Likewise a role with independence was often suggested by participants, such as a Board member or a Non-Executive Director, but only with some prompting beforehand.

Many participants mentioned their union as a possible alternative for raising concerns, although in discussion it was recognised that unions may not be able to deal with the issue themselves. In the course of a couple of sessions, union representatives commented on how the unions were perhaps poorly placed to deal with concerns raised with them. There may be a conflict of interest relating to those accused in some matters, as well as the fact that they would be looking to protect the worker, not deal with the concern raised.

It was particularly surprising how little the regulators within the sector, RQIA and NISCC, were proposed during discussions as a forum for concerns. Even where they were cited as a body that could be approached in the organisation's whistleblowing policy, there was generally confusion as to how this might be achieved. This seemed to be a distinct gap in reporting structures.

There was a strong and consistent message from participants that the media had little role to play in getting concerns dealt with effectively. A number of media shows and personalities were the subject of particular comment and criticism. Several participants commented on how the media's agenda of entertainment rarely aligned with the whistleblower's aim to get problems solved, and that this often resulted in a lack of responsibility and proportionality when handling the issue.

Although the topic was only covered in a small number of sessions, it appeared as if there was a complete lack of knowledge that there was legislation protecting whistleblowers from detriment, or any legal element to the protection of those who raise concerns within the workplace. Hence there was a very low awareness of the Public Interest Disclosure Order 1998.

Trust and Confidence

The only consistent message from the groups on how whistleblowers could be protected from negative consequences was by the protection of their identity.

Generally, the only way that participants felt they could be protected, was by their identity not being associated with the concern. There was confusion around the difference between a concern being raised anonymously (where no-one knows who it is that has provided the information) and confidentially (where one or more individuals know the identity of the whistleblower but protects that identity during the course of the investigation).

Views were mixed on whether confidentiality would be respected by those handling the concern. One prominent view was that confidentiality in the Northern Ireland's health service didn't really exist; communities were too closed and interlinked. Several participants commented on how multiple members of a family might commonly work in the same unit or the same trust, and so the likelihood of the 'rumour mill' operating to uncover the identity of the person who raised the concern, was considered to be very high.

For many, the option of confidentiality was seen to be a desirable element of protection for staff that raised a concern; they commented on how they had no reason to believe that managers wouldn't protect their confidence in these situations.

It was stated consistently from those tasked with handling investigations, that in most instances, it was almost impossible to investigate anonymous concerns. Additionally, those involved in a number of investigations advised that anonymous concerns can be extremely damaging to team morale.

From this perspective, it appeared that raising concerns anonymously was appealing from a protection point of view, but it was not generally an effective way of getting problems dealt with. Furthermore, one individual who contacted PCaW talked passionately about the effect that anonymous concerns can have on the wider workforce and the potential for them to be used vexatiously. This participant described how a series of anonymous disclosures had bred a culture of paranoia and had eroded staff confidence.

In response to how whistleblowers can be protected, participants rarely suggested that managers have a role to play.

Very few participants put forward the idea that the actions of management played a role in protecting whistleblowers from victimisation. That said, once the idea was put to groups, individuals generally agreed that managers could directly support the whistleblower. Generally, it was suggested that the best way this could be achieved was by being seen to take firm action against those who victimised whistleblowers, rather than actually being able to stop the victimisation in the first place.

Many participants commented on how this no tolerance approach needed to extend to management, especially in cases where no action had been taken by them after a concern had been raised.

While staff having confidence that their concerns will be dealt with is an important piece of the puzzle, several groups commented on how it was also important to have confidence that the receiver of concerns would not overreact. This formed the basis of some discussion in several of the groups interviewed, particularly in relation to minor issues raised anonymously. It was felt that there could sometimes be a lack of proportionality when the whistleblowing policy had been invoked, and those accused in these circumstances were subsequently not sufficiently supported. This was a theme that was raised at several of the groups and at different organisations. There is clearly a need for proportionality and fairness for those accused of wrongdoing, as well as for the individual raising the concern.

Participants regularly commented on how the most common aim of the whistleblower was to have the concern addressed and not for there to be serious repercussions for staff or the unit. A fear of unnecessary repercussions was highlighted as a factor which may prevent people from highlighting concerns.

Generally participants were confident that if they raised serious issues with their managers then they would be dealt with.

In some groups, however, there was an understanding that this might not be so true of concerns that were linked to funding, such as understaffing.

Several non-senior auxiliary staff that attended the focus groups, expressed doubts as to whether they would be listened to if they raised concerns. This could be a missed opportunity, given that these staff are very much the eyes and the ears of the organisations, and will often be the first to observe any problems.

Conclusions

From the outcomes highlighted in this section of the report: the combination of a lack of understanding around what is contained within whistleblowing policies; a fear of negative repercussions; and a sense that raising a concern may be futile; do not facilitate effective whistleblowing arrangements.

The review team considers that as a minimum, training or awareness raising sessions should be developed to improve staff awareness and understanding of the whistleblowing process, together with communication focusing on how the whistleblowing policy is more than a safety net for other every day reporting mechanisms. Furthermore, it should be considered whether work can be done at an organisational level, to make potential whistleblowers feel supported and protected, reducing the reliance on anonymity for safety.

It is to be hoped that such work may go some way to normalising the whistleblowing process and overcoming the existing staff perceptions and misunderstanding of whistleblowing.

2.5 Meetings with Senior Teams

As part of the review, the review team met with senior managers from each of the organisations, who had responsibility for oversight of whistleblowing arrangements. The discussions focused on the operation of their respective whistleblowing arrangements and what could improve whistleblowing across health and social care. The discussions were very constructive and form the basis of the conclusion section of this report.

2.6 Stakeholder Event

In April 2016, as part of the review methodology, RQIA hosted a stakeholder event which was themed 'Raising Concern, Raising Standards'. It provided an opportunity for a range of staff working across different HSC organisations to discuss the initial findings from the review, identify arrangements for whistleblowing in other jurisdictions and discuss potential next steps that may be included in the final report.

During the event, one reviewer shared their own personal experience of being involved in a whistleblowing case; a representative from the Scottish Government outlined the development and current arrangements for raising concerns in Scotland; PCaW presented the initial findings in relation to the assessment of the whistleblowing policies and the staff engagement; finally, the review team presented the initial findings from the review.

Participants discussed the findings with members of the review team and were also involved in group discussions regarding next steps, in relation to:

- changing culture within organisations
- arrangements for recording and reporting concerns
- future oversight arrangements

Changing Culture within Organisations

Participants accepted there was a need to change the culture within organisations in relation to raising concerns. As the organisations were fundamentally different, a single solution would not fit. Some participants proposed that the equality and diversity agenda may be a suitable mechanism to facilitate this.

It was acknowledged that further clarity on raising concerns needs to be provided for staff. This could be achieved through improved communication about raising concerns and training for all staff within the organisations.

Participants suggested that more advertising and promotion of raising concerns was needed, such as, posters or campaigns to increase awareness. Encouragement and praise would also be required to demonstrate the positive outcomes of raising concerns. This should be supported by a more visible demonstration of management's commitment to raising concerns.

Participants all understood that changing organisational culture was a huge task, and would not be achieved immediately. However, implementing some of the areas they proposed would be an initial step in the right direction.

Arrangements for Recording and Reporting Concerns

Participants felt this was an area that could not be solved in a single workshop, due to its complexity. However, they proposed many very sensible and useful suggestions.

Putting in place appropriate mechanisms for recording and reporting was acknowledged as a task which would require input from all stakeholders. Given the size and complexity of the different organisations, it was recognised that the mechanism may be different for each organisation.

In relation to what, when and how often things should be recorded and reported, participants considered that individual organisations and stakeholders would have to determine how this was taken forward. Key areas for further discussion and development were proposed, such as:

- formal or informal reporting and the exceptions
- differentiating between concerns and other issues, such as, grievances or complaints
- methods of raising concerns and how these are captured
- internal or external reporting and the mechanisms to achieve this
- lessons that could be learned from the concerns raised and how this could be shared

Participants highlighted that there are many existing mechanisms for recording and reporting activities throughout all organisations. Rather than invent something new, existing mechanisms should be considered as possible ways to support recording and reporting of concerns. Learning arising from appropriate recording and reporting of concerns should be shared throughout the organisations.

Future Oversight Arrangements

During the stakeholder event, presenters outlined the details of the oversight arrangements for raising concerns in England and Scotland. Participants then discussed the merits of the different arrangements within the context of Northern Ireland.

In conclusion, it was acknowledged that oversight arrangements for whistleblowing already exist in Northern Ireland, through DoH. Participants considered that some clarity on any proposed oversight arrangements was required, to determine what they were designed to achieve. It was proposed that rather than setting up new bodies or developing new arrangements, existing arrangements should be revised to ensure they provide appropriate outcomes in relation to raising concerns.

Participants acknowledged that much work was required in relation to setting up appropriate arrangements and mechanisms for raising concerns, which would require input from all stakeholders.

Section 3 – Conclusions and Recommendations

3.1 Overall Conclusions

Policy Development

Throughout the review, a recurring theme was the use of the term whistleblowing. Whistleblowing was universally seen as a very negative term, which was not helped by the media's portrayal of cases of whistleblowers. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There was also confusion as to what the term actually referred to; some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation. Other staff considered that whistleblowing was about something that involved criminal wrongdoing such as fraud, rather than being about a patient safety concern. There was also confusion as to where whistleblowing fitted into existing reporting procedures such as incident reporting. Focus group participants saw incident reporting as just part of their job but were not really aware as to when their organisation's whistleblowing policy might be used.

In his review of whistleblowing in the NHS, Freedom to Speak Up, Sir Robert Francis gave consideration to recommending that the term whistleblower should be dropped. Even though there were reservations about its continuing use, he had been persuaded that the term was now so widely used that removing it would not succeed. PCaW considered that removing a word from internal publications would not stop the public and the media from using it. There is a danger that the word may shift its meaning to denote only those rarer forms of raising concerns, which may only further entrench the stigma towards whistleblowing.

The review team is aware that removing a single word from the vocabulary of HSC policy will not automatically lead to an improved culture of raising concerns. However, they consider that in light of the overwhelming negative view of the term whistleblowing and the fact that it might be actively preventing proper reporting of the full range of concerns, it should not be the main title of any policy in relation to raising concerns, as this immediately takes the reader to the end point of what should be a spectrum of raising concerns.

All organisations subject to the review had a whistleblowing policy in place. Although a number had been updated, it seemed that most policies were based on guidance provided by DHSSPS in February 2009. In its review of existing HSC policies, PCaW considered that a number were overly legalistic and tended to use language associated with handling of complaints or grievances, which is not conducive to encouraging staff to use the policy.

The review team considers that whistleblowing is only one step along a continuum or spectrum of raising concerns and may be seen as the end point of raising a concern. Concerns are raised and dealt with daily and most may be resolved quickly and informally. However, for more serious concerns, there needs to be a more formal process. The process needs to provide clarity to the person raising the concern as to what will actually happen next, to how they will be kept informed of progress, and eventually how they will be informed of the outcome as a result of their raising a concern. Any policy should reflect the reporting of both formal and informal concerns and should culminate in providing advice about other organisations a member of staff may go to when they feel it is appropriate. The policy should also easily distinguish between raising concerns and incident reporting and act as a signpost as to where concerns would be best addressed.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for Northern Ireland that reflects current thinking. The policy should consider the negative connotations associated with the term whistleblowing and take account of the whistleblowing code of practice and recent policies such as the Department of Finance and Personnel Whistleblowing Policy[33] and the new policy – Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS, which was developed following the Robert Francis Review[34].

The review team considered feedback that indicated that a one size does not fit all and one policy would therefore not be the best way forward; however, this approach has already been taken in both England and Scotland and the review team considered this would be the best approach for Northern Ireland. It should be emphasised that all organisations could individualise the policy to take account of their particular situation.

The review team has made recommendations for improvement to the arrangements to whistleblowing across health and social care. The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report:

- Priority 1 - completed within 6 months of publication of report
- Priority 2 - completed within 12 months of publication of report
- Priority 3 - completed within 18 months of publication of report

Recommendation 1	**Priority 1**
The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	

[33] Department of Finance and Personnel – April 2011 - https://www.dfpni.gov.uk/publications/dfp-whistleblowing-policy
[34]Freedom to speak up: raising concerns (whistleblowing) policy for the NHS - April 2016 - https://improvement.nhs.uk/uploads/documents/whistleblowing_policy_30march.pdf

Effective Leadership

All organisations provided evidence of having extensive governance arrangements in place, with some demonstrating good integration with quality improvement and organisational learning programmes.

There was an awareness of the need to create an open and honest culture, and many organisations demonstrated their understanding of the need for visible leadership. A number of methods were used to achieve this, with senior management and board member walk rounds being the most popular. Other methods included staff open forums where senior staff were available to listen to staff concerns. In one organisation these concerns were logged in order to try to facilitate feedback. This was considered to be a very positive development which also led to better feedback to those who raised a concern.

A learning and development steering group has been developed in an organisation, chaired by a non-executive board member, which discusses concerns and uses scenarios to elicit learning which is then passed through the organisation.

The review team considered that these were extremely positive steps but that further development in this area was necessary. The review team also considered that it was important to assess the effectiveness of any developments in this area.

Recommendation 2	**Priority 1**
All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	

Reporting to organisational boards is also an important step in assuring that raising concerns is seen as an integral piece of organisational governance. It was unclear to the review team that this was happening to any great extent and it seemed to be very much left to individual judgement as to what was or was not reported.

The very extreme examples of what would ordinarily be termed whistleblowing would be brought to boards, but the review team considered that the principle of normalising raising of concerns had not yet become part of day to day practice.

Concerns that had not reached a particular threshold were not being recorded or passed up the chain to organisational boards. However, there were areas of good practice where service users and employees were offered the opportunity to attend board meetings to report on their experiences.

To ensure further development in this area, the review team considered that a non-executive board member should be appointed to have responsibility for overseeing the culture of raising concerns within each organisation.

Recommendation 3	**Priority 1**
Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	

Staff Training and Awareness

Policy development and leadership are important steps in development of a culture that openly normalises the raising of concerns, making it part of day to day business. Staff awareness and ability to understand and be comfortable with the process of raising a concern are also vital components of any system.

On the positive side, both the HSC and RQIA surveys indicated that a large percentage of staff knew their organisation had a whistleblowing policy in place. The HSC survey also reported that the majority of staff (80%) would be confident to speak up and raise a concern. The majority of staff responding to the RQIA survey would feel comfortable in approaching their line manager to raise a concern (80.9%).

However, a lesser percentage (65%) of respondents to the HSC survey indicated that they felt their organisation would handle their concern appropriately. 55.4% of staff who responded to the RQIA survey had confidence that their organisation would carry out a robust investigation of any concern they might raise and only 52.5% would feel comfortable reporting a concern to a senior member of their organisation. This identifies that approximately one third of staff responding to the HSC survey feel their organisation would not handle their concern appropriately.

841 members of staff who had raised a concern within their organisation responded to the RQIA survey. 477 (56%) of these respondents considered that their concern had not been dealt with appropriately and 572 (68%) had not referred to the organisation's whistleblowing policy. 372 (44.2%) considered that they had suffered detriment as a result of raising that concern.

While the survey numbers are small, the results indicate that although staff are aware of whistleblowing policy and procedure, a number are not confident that if they raised a concern it would be dealt with appropriately. Of those who had raised a concern, over half felt their concern had not been dealt with appropriately.

The majority of staff attending focus groups were also aware of the existence of a whistleblowing policy but few were aware of what it contained. However, once again staff felt confident about approaching their line manager.

It was noted that several non-senior auxiliary staff expressed doubt as to whether they would be listened to if they raised concerns.

It was identified that many staff had a limited understanding of whistleblowing and the associated process for raising a concern. If advice and support was readily available to them, this may have increased the number of concerns raised.

A whistleblowing helpline has been established by the Department of Health in England. The helpline is provided free of charge, staffed by specially trained advisors and provides advice to individuals at all stages of the spectrum of raising concerns, from those thinking about speaking up to those who have suffered as a result.

On 2 April 2013, The Scottish Government, in its response to the Francis Report, launched The National Confidential Alert Line for NHS Scotland. This helpline was managed by PCaW, and was designed to provide a safe space where staff could raise concerns about patient safety and malpractice. Staff could also obtain advice and support if they felt they had been victimised as a result of whistleblowing. Following what was considered to be a successful pilot, the Confidential Alert Line was continued after receiving further funding.

To demonstrate a commitment in relation to raising concerns within Northern Ireland, the review team considered that DoH should establish a pilot confidential helpline. The helpline should provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland.

In line with the Scottish approach, the helpline could be run as a pilot for a period of at least one year, with an evaluation prior to the pilot finishing to decide whether or not to continue with it. Data from the calls should be used in the evaluation and also to support learning.

Recommendation 4	**Priority 1**
The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	

All senior staff reported that the whistleblowing policy formed part of a staff induction process. The policy was then made available on organisational intranets. Other methods of raising staff awareness included a Raising Concerns Booklet, staff notice boards, posters and screensavers on employee computers.

One organisation is currently developing an e-learning package for staff, and another had developed a training package to be delivered across middle management which will place an emphasis on "ringing bells" rather than "blowing whistles", in order to decrease the negativity around being seen as a whistleblower. These were seen by the review team as positive developments.

However, beyond this no further training or awareness sessions were carried out and no organisation tested staff awareness on an ongoing basis. It was also unclear as to the level of training provided for line managers and all other managers with responsibilities outlined in whistleblowing policies.

The review team considered that for a system of raising concerns to work effectively, awareness training needed to be available for staff in how to raise concerns but also in relation as to how raising a concern fits in the overall governance process, including incident reporting complaints etc. For operational staff, this could indeed be part of induction but needed to go further than just being made aware of the existence of a policy. Managers need to be provided with the competence and confidence to enable them to respond to and address concerns raised with them.

Specific training also needs to be available for all staff involved, including managers, in the operation of the process for raising concerns. The review team considered that following development of any new policy, awareness training and bespoke training in relation to raising concerns should be developed for staff. This work may involve utilising existing training resources or the development of new e-learning packages.

Recommendation 5	**Priority 2**
Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	

Recommendation 6	**Priority 2**
All managers should receive bespoke training in the operation of their policy for raising concerns.	

As well as the provision of training, assessing the effectiveness of any training provided is also important. One method of assessing staff awareness of raising concerns and the effectiveness of any training provided is through staff appraisal. Appraisal also provides an opportunity to emphasise to staff, the importance to the organisation of raising concerns. The review team discussed appraisal rates during meetings with senior teams.

Appraisal rates in the small organisations were mainly good; however, appraisal rates in the larger organisations varied between 42% and 80%. It is not uncommon for smaller organisations to have a higher appraisal rate than in the larger organisations; however, the review team considered that appraisal rates in some organisations were very low and efforts should be made to increase the uptake of staff appraisal.

Recommendation 7	**Priority 1**
All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	

Organisational Oversight

One of the recommendations of the Freedom to Speak Up review was in relation to where responsibility for the daily oversight of the process for raising concerns should be situated. In the majority of organisations in the United Kingdom, responsibility lies with the HR department. However, the Francis review questioned as to whether this was appropriate. HR may be seen as threatening, as it is the department that will take the lead in grievance processes and processes to deal with poor performance. The Francis report made the recommendation that:

“To reinforce the concept of raising concerns as a safety issue, responsibility for policy and practice should rest with the executive board member who has responsibility for safety and quality, rather than human resources”.

A number of organisations reported that having whistleblowing under the responsibility of HR worked well for them, and saw no reason to change. Some of the smaller organisations may also see any change being difficult as a result of their size. There is logic, however, that if the raising and reporting of concerns becomes part of everyday culture, responsibility may best sit elsewhere within governance reporting structures. This would then allow HR departments to become more independent when it comes to any concern that required further investigation.

The review team does not feel that it can be prescriptive as to where responsibility is best placed, but would recommend that when a new policy is developed, consideration should be given as to where best responsibility for oversight sits.

Recommendation 8	**Priority 1**
All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	

Effective Feedback

One of the principles contained in the Whistleblowing Code of Practice is that a member of staff who has raised a concern should be told, where appropriate, the outcome of any investigation. The Freedom to Speak Up report also considered that feedback was an important part of the process.

The review team considered that any change in practice/procedure should take place at both an operational and an organisational level. The review team was told that organisations mostly did not record concerns and also did not feedback what action was taken as a result of raising a concern. That is not to say that there was no feedback at all, and several organisations described multiple feedback methods including newsletters, staff briefings and learning reports. One organisation, perhaps as a result of previous incidents, had a more developed culture of raising concerns, was reflecting these on risk registers and when resolved, feeding back to those involved in raising the concern.

Any method of feedback is to be supported, but feedback to individuals is essential. Using the mediums described did not emphasise that learning and any change in practice, was as a result of reporting a concern. The review team also considered this would be an important step towards normalising the raising of concerns.

Recommendation 9	**Priority 1**
All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	

Local Advocates

The Freedom to Speak Up report suggested that organisations develop local champions in relation to raising concerns. The functions of a local champion included:

- ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- intervene if there are any indications that the person who raised a concern is suffering any recriminations
- work with HR to address the culture in an organisation and tackle the obstacles to raising concerns

An example of the development of local champions is the appointment of advocates in relation to raising concerns in Guys & St Thomas' NHS Foundation Trust.

The role of an advocate in the trust is one of support for members of staff who wish to raise concerns and to help them to determine the most appropriate way for their concern to be dealt with. In their role profile, advocates "provide immediate support and signposting for staff members raising concerns, determining the best course of action and advising the staff member of their options. It is not envisaged that the Advocate would take on the concern but rather support the staff member to effectively raise their concern, where appropriate, or seek an alternative course of action."

The review team considered that the development of advocates at a number of levels, especially in larger organisations, may contribute to development of a more open culture in relation to raising concerns.

Recommendation 10	**Priority 2**
All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	

Independent Oversight

The Freedom to Speak Up review recommended that an Independent National Officer be appointed, with functions that include:

- reviewing the handling of concerns raised by NHS workers where there is cause for concern in order to identify failures to follow good practice
- advising the relevant NHS organisation, where any failure to follow good practice has been found, to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it makes a direction requiring such action
- acting as a support for Freedom to Speak Up Guardians
- offering good practice advice about handling concerns
- publishing reports on the activities of the office

The Scottish government has also committed to the development and establishment of an Independent National (Whistleblowing) Officer, to provide an independent and external review on the handling of whistleblowing cases.

The topic of whether or not Northern Ireland should have such an oversight body was discussed during a number of organisational meetings and also at the stakeholder event. The consensus of opinion seemed to be that due to the scale of the system in Northern Ireland, there was no need for such an appointment and the review team agreed with this point of view. However, the review team considered that there should be some ongoing oversight at an operational level as to whether processes for raising concerns were effective.

RQIA carries out reviews and inspections in acute hospitals, assessing them against the domains of safe, effective, compassionate care and well-led. The review team considered that progress in relation to normalisation of raising concerns may be included as part of the well-led domain of the RQIA regulatory process. This would provide assurance in the larger trusts, and DoH should consider how this could be taken forward in the smaller Arm's Length Bodies.

Recommendation 11	**Priority 1**
RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	

All organisations recognise that raising concerns is one essential element of an open and transparent culture. All organisations felt that they had an open and transparent culture but were unclear as to what evidence could be produced to substantiate this claim. All organisations quoted the results of the HSC survey and a number quoted having gained Investors in People as measures that all was well with the culture in their organisation. These are positive developments and not to be underestimated, but are quite high level measurements.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. The review team considered that most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

Northern Ireland has a very low level of whistleblowing, and again, organisations used this as another measure of demonstrating that all is well. The lack of whistleblowing cases may indeed reflect that systems are working effectively; however, it may also be evidence that the system is not working at all. The reason for a very small number of cases may be that staff do not have confidence that there will be positive outcomes for them or their organisation, as a result of raising a concern.

What should be reported and recorded in terms of raising concerns was also the subject for much discussion during organisational visits and also during the stakeholder event. It is accepted that not every conversation that takes place between a line manager and a member of staff needs to be recorded; however, there must be a threshold beyond which a concern should at least be recorded in the system.

Identifying a threshold for recording concerns will enable better monitoring of trends and will help to normalise the raising of concerns, which could contribute to a more open and honest culture.

It would also:

- facilitate the process of feedback to staff who have raised a concern
- enable outcomes, in terms of change in practice, to be demonstrated

Such feedback has the added advantage of making staff feel valued and helps them to understand what they do actually matters. It again has to be emphasised that it is not the intention of this review to create yet another industry around reporting and recording of concerns.

Organisations already have strong governance processes in place and raising concerns should become part of normal day to day governance. Awareness raising for all staff and training for managers should provide them with the skills to assist with the process.

Due to the diverse nature of the organisations, it is very difficult to make specific recommendations aimed at developing an open and honest culture. This is something that organisations must develop themselves. Organisations must also identify ways of demonstrating that they are working towards developing such a culture that fits their particular circumstance. All organisations must also decide what level of recording and reporting they feel is appropriate for them. The review team considers that it is not acceptable for organisations to assume that a low level of raising concerns is positive. They must each 'test the silence' using a range of metrics and indicators to build a picture of the 'health' of individual directorates/divisions/departments. This will provide assurance as to whether the process of raising concerns is working well in their organisation.

The review team understands the difficulty in prioritising raising a concern/ whistleblowing when it is competing against a wide range of other priorities. It may be that there are low levels of concerns in Northern Ireland. However, if these small numbers are not treated appropriately, then many more staff will learn from this negative experience that it is better not to speak up.

Culture change will not occur overnight and striving for a true open and honest culture is an ongoing and perhaps never ending process. Normalising the reporting of concerns is only one building block of an open and honest culture; however, it can be an important issue in terms of patient safety.

This report and the recommendations contained within it are designed to create a framework where all staff understand the need to report appropriate concerns and feel totally comfortable raising those concerns.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review, and the contributions from the other stakeholders for their input.

3.2 Summary of Recommendations

The recommendations identified during the review have been prioritised in relation to the timescales in which they should be implemented.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Implementation of the recommendations will improve the arrangements for raising concerns.

Number	Recommendation	Priority
1	The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	Priority 1
2	All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	Priority 1
3	Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	Priority 1
4	The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	Priority 1
5	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	Priority 2
6	All managers should receive bespoke training in the operation of their policy for raising concerns.	Priority 2
7	All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	Priority 1
8	All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	Priority 1

9	All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	Priority 1
10	All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	Priority 2
11	RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	Priority 1

Appendix 1 - Abbreviations

CQC	- Care Quality Commission
DHSSPS	- Department of Health, Social Services and Public Safety
DoH	- Department of Health
HR	- Human Resources
HSC	- Health and Social Care
INO	- Independent National (Whistleblowing) Officer
NAO	- National Audit Office
NHS	- National Health Service
NISCC	- Northern Ireland Social Care Council
PCaW	- Public Concern at Work
RQIA	- Regulation and Quality Improvement Authority
Southern Trust	- Southern Health and Social Care Trust

Appendix 2 – Staff Suggestions from Focus Groups

At the end of each focus group, participants were asked to propose some suggestions as to how their organisation could improve its whistleblowing arrangements. Those suggestions that were in effect a differently worded version of the same idea were grouped under a common heading. Furthermore, in processing the data captured, suggestions were grouped together in certain themes.

What follows is a summary of the findings.

Top Suggestions	
Training (no further specification)	33
Training for management	12
Mandatory training	11
Awareness, improvement through posters etc.	11
Assurances for confidentiality	9
Use different term	7
E-learning	6
Interactive awareness/workshop sessions	6
Independent whistleblowing contact in the trust	5
Talk about whistleblowing in team meetings	5
Flowchart/poster to show channels in raising concerns	4
Publication of positive outcome whistleblowing/reporting of number of cases	4
Feedback for whistleblower	4
Better support for whistleblower	4
Shortening investigations/clear-cut timeframes	4
Increase awareness of policy	4

Over 40% of all suggestions related to the need for training around whistleblowing.

While this was a huge finding, when considered alongside the findings of the main staff engagement report, it is perhaps not that surprising. It was clear that throughout the sector there was a lack of knowledge and understanding around the core principles of whistleblowing, right down to what the term even refers to. As a means of educating staff, training is the obvious solution to this problem.

Of those suggestions captured under the theme of training, there were some consistent more specific suggestions. The most common of the specific ideas (29%), was that there should be specific training for management around whistleblowing. This suggestion seemed largely borne out of the gross negative effect that management can have on the system if they don't handle instances appropriately. Many participants suggested that training should be mandatory, although many people felt that this would be unworkable, given the already large amount of training that needed to be undertaken.

One proposal that made up 15% of the training suggestions was to have compulsory e-learning. Several participants spoke of how this was a manageable and often quite effective way of conducting training.

The second most common grouping of suggestions related to ways in which management communicated to the staff body – i.e. management messaging.

Interestingly, similar to training detailed above, these sorts of suggestions also related to the way in which staff could be educated about whistleblowing. The most common suggestion (42%) in this category was a poster campaign designed to improve awareness around whistleblowing. Another popular idea as to how information on whistleblowing could be communicated was via a regular slot in team meetings. Many participants felt that this may normalise the process.

Another idea that was repeated on several occasions was to have flowcharts posted in wards detailing options for raising concerns, and in what order they should be attempted. Not all suggestions in this grouping related to informing staff of the arrangements for whistleblowing. It was also considered by some participants that management messaging could be used as a way to improve trust and confidence in the organisations whistleblowing arrangements. The most popular of these suggestions was for the organisation to publicise successful instances of whistleblowing where the problem was solved and the whistleblower unaffected. Many participants questioned the feasibility of this given various duties of confidentiality; however, the benefits of countering the media's overwhelming negative portrayal were seen to be a very worthwhile goal.

How concerns are handled (15%), points of contact for raising concerns (8%) and the term *whistleblowing* itself (6%), were all also popular topics.

Approaches to improving handling were mainly directed at improving things for the whistleblower. This made up 88% of the suggestions in this group, and this aim was evenly split between better protection of the whistleblower's identity (to avoid victimisation) and better support for the whistleblower. In the former category the prevalent view was for greater assurances around confidentiality, whereas in the latter sub-group, views were spread across better support, feedback for the whistleblower and shorter, or better time framed, investigations. Generally, this was slightly out of step with the views expressed in the sessions themselves, where protection of identity was often seen as the only way of making things better for whistleblowers. This might reflect the fact that participants had just not thought of other ways the organisation could improve measures, and that once this was put to them they saw the value in it.

Very often in the focus groups, there were discussions about what, if anything, to do with the term whistleblowing, given the negativity that surrounded it.

This unsurprisingly manifested itself in a significant proportion of participants putting forward suggestions related to this. The vast majority of suggestions were to change the name as means of escaping the stigma, although some participants suggested that a better route was to try and normalise it.

The majority of suggestions (71%) related to points of contact were for more internal options. The most common of these was for an independent whistleblowing contact within the organisation who sat outside of the line management chain.

Although a much smaller share of the total suggestions, many participants also put forward suggestions relating to the organisation's policy (5%) and the advice available to whistleblowers (3%).

Training		Points of contact		Messaging		Handling		The term		Advice		Policy		Other		
Mandatory training	11	Independent whistleblowing contact in the trust	5	Awareness improvement through posters etc	11	Joined up policy for incident reporting	1	Use different term	7	Independent source of advice	3	More accesible policy	3	Online system for raising concerns	2	
E-learning	6	Independent reporting contact outside of the trust	2	Flowchart/poster to show channels in raising concerns	4	Gateway teams' for handling whistleblowing concerns	1	Increase use of the term to familiarise/normalise it	3	Better awareness of advice available	1	Forced reading of policy	1	Cross-trust investigations	1	
Training for management	12	Senior management more visible / drop-in	2	Encourage staff to raise concerns	2	Improving audit of existing reporting arrangements	1	Better understanding	1	For managers	1	Simplified policy	1	"Have no fear of repurcussions for whistleblowing"	1	
Interactive awareness/workshop sessions	6	Make reporting to senior management more straight forward	3	Talk about whistleblowing in team meetings	5	Assurances of confidentiality	10			On site advice	1	Increase awareness for policy	4	Responsibility for whistleblowing devolved to invidividual departments	1	
Training on policy	2	Independent external body that can mediate	1	Publicisation of positive outcome whistleblowing / reporting of number of cases	4	Feedback for whistleblower	4							Independent panel within trust to investigate whistleblowing concerns	2	
Training to complete at home	1	Making contacting RQIA easier	1			Better support for whistleblower	4							Code of practice for management in dealing with concerns	1	
Training on distinguishing from other reporting lines	1					Shortening investigations / clear-cut time frames	4							Discipline managers who breach confidence	2	
Training for investigators	1					Guaranteed anonymous way of raising concerns	2							Improve confidence in reporting	1	
Induction training	1															
Training (no further specification)	33															
	74		14		26		27		11		6		9		11	178
	41.57%		7.87%		14.61%		15.17%		6.18%		3.37%		5.06%		6.18%	100.00%

Appendix 3 – Case Studies

During each day of focus groups, an opportunity was provided for those with first-hand involvement of whistleblowing to talk with PCaW directly, so that their experiences could be included within the report.

There were several stories which PCaW felt, given the sensitivity of the case, would not be appropriate to include. This was due to a risk that the individual would be identified by the nature of the facts and their situation could potentially be made worse.

Of those stories that PCaW felt could be anonymised, a selection of these case studies have been detailed below. In addition to telling the individual's unique story, while still retaining the spirit of the experience, the case studies demonstrate some of the more general challenges faced in getting whistleblowing arrangements right.

Potential Consequences

Several participants spoke about the potentially damaging, and unnecessary effects that whistleblowing can have on their own personal circumstances. One of these stories highlighted the stark contrast between the positive change that the person was trying to make and the eventual personal cost that they had to endure.

An individual advised of raising serious concerns about another colleague, who apparently in a fit of temper, had shouted, man-handled and took away the belongings of a patient who had severe pre-existing anxiety issues. The whistleblower took the concerns to their manager, but fearing a reaction from the staff member implicated, had requested that their identity be kept confidential.

Confidentiality was not maintained and the disclosure eventually made its way back to the guilty party, who apparently then proceeded to manipulate the team against the individual who raised the concern. The individual advised that trusted colleagues turned against them, resulting in the individual suffering stress and distress, and subsequently having to take time off work. The individual described in vivid terms how their health, both physical and mental, deteriorated as they tried to cope with the circumstances.

Although the individual was back in employment and generally recovered, they described the intense anger they had towards the way that their manager had handled the incident. The lack of confidentiality resulted in challenging times for the whistleblower, and a presumed knock-on effect of fear, for anyone who might think of raising a concern in the future.

Anonymous Concerns

During a one-to-one session, a participant described their experiences of the effects that anonymous concerns can have on staff, and the delivery of service. The individual worked in a clinical environment which had, over the course of a short period of time, been the subject of several anonymous letters written to senior management. The participant explained that the consequent long investigation times and lack of knowledge surrounding the issues permeated a culture of fear, distrust and uncertainty throughout the team. They advised that there was a clear loss of morale and suggested that the service provided was less effective, as staff no longer trusted their instincts and were constantly checking every decision with management.

Of the concerns where investigations had concluded, the participant advised that no action had been taken. The participant acknowledged the need for workers to be able to raise their concerns in any way possible, but stated that these incidents had come at a high cost for their team. They advised that the team was also no clearer as to the specific circumstances surrounding the concerns, and rumours had spread that the concerns raised were vexatious. The participant questioned what action their team or the trust could do to protect themselves in this instance.

Challenges for Trade Unions

On many different occasions there were discussions about the role that the trade unions played with respect to whistleblowing. Many participants advised that if they were unsure how to raise concerns, or needed support in doing so, they would approach their trade union.

A core function of the Union is their duty towards their members. This however, became a particular challenge in cases where they had to support staff on both sides of a concern.

Handling of Concerns by Management

During the course of the staff engagement exercise, PCaW met with a clinician in one of the trusts, who described how multiple members of the staff had separately raised concerns about a particular site. The individual explained how staff not only had identified problems, but also suggested practical and attainable solutions.

The clinician advised that staff felt they were unable to escalate their concerns beyond a particular level of management, the positions became entrenched, relationships broke down, and ultimately the concerns remained. The situation has since improved; however, according to the individual, many of those involved in raising the concerns left the organisation, as a result of how this was handled.

Lack of Feedback – a Missed Opportunity for a more Positive Outcome

For many whistleblowers, the potential victimisation from colleagues can be a major concern. This was a particular concern for one individual who spoke with PCaW.

An individual advised of being concerned about the level of professionalism by some managers within the team, and the knock-on effect that this was having on the service users.

They advised of following the whistleblowing policy, and stated that initially it worked well for them, as it provided an avenue for the concerns to be raised outside of line management. However, once the concerns had been detailed to senior management, the individual stated that they were considered no longer involved in the process. They stated that HR sometimes contacted them, but not with any updates in relation to the concerns.

Due to the lack of feedback, the individual stated that they could only speculate on what was happening. They did not know, and were concerned about, whether others knew that they raised the concern. The individual advised of becoming somewhat paranoid about any potential consequences. As a result, they advised of becoming stressed, which was starting to impact on their health. They found it hard to cope and subsequently had to take time off work. After an extended period of absence, they advised that they are only now starting to get back to normal.

The participant described how whistleblowing, even when they are not directly involved, can be an extremely stressful experience, and especially when there is no support during the process.

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010

Review	Published
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013

Review	Published
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

Review	Published
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory Services in Northern Ireland	February 2016
Review of the Northern Ireland Ambulance Service	March 2016
Review of HSC Trusts' Readiness to Comply with Allied Health Professions Professional Assurance Framework	June 2016
RQIA Publishes Overview of Quality Improvement Systems and Processes in Health and Social Care	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016

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Assurance, Challenge and Improvement in Health and Social Care

YOUR RIGHT TO RAISE A CONCERN (WHISTLEBLOWING)

HSC FRAMEWORK & MODEL POLICY

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INTRODUCTION

1. Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

2. Encouraging staff to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage, corrective action can be put in place to ensure safe, high quality and compassionate care.

3. The importance of raising concerns at work in the public interest (or "whistleblowing") is recognised by employers, workers, trade union and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place[1].

DEFINING WHISTLEBLOWING

4. Whistleblowing is defined as "when a worker reports suspected wrongdoing at work"[2]. The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences such as those highlighted in the Mid Staffordshire Report (2013)[3].

[1] Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)
[2] *Government Whistleblowing Policies* National Audit Office (2014)
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

5. Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:
   - patient safety;
   - health and safety at work;
   - environmental damage; or
   - a criminal offence (e.g. fraud).

6. Whistleblowing can also be broadly defined as simply ‘raising a concern’[5]. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the HSC Complaints Procedure. However, whistleblowing is different from making a complaint or raising a grievance. Whistleblowers can often act out of a feeling of fairness or ethics rather than a personal complaint. As Public Concern at Work (PcAW) states, it is important to note that:

   “....*the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it*”.[4]

WHY DOES WHISTLEBLOWING MATTER?

7. Staff who are prepared to speak up about malpractice, risk, abuse or wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation by identifying and addressing problems that disadvantage or endanger other people[5].

[4] Where’s whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010

[5] Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work

8. It is important for individuals to feel safe and listened to when raising concerns. An open approach to whistleblowing promotes the values of openness, transparency and candour and encourages employees to treat patients and service users with dignity, respect and compassion.

9. From the employer's point of view, there are good business reasons for listening to staff who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place.

10. From the staff members' perspective, the freedom to raise concerns without fear means that they have the confidence to go ahead and "do the right thing". It is part of encouraging staff to reflect on practice as a way of learning[1].

SCOPE

11. This Framework and Model Policy has been developed in response to the recommendations arising from the Regulation and Quality Improvement Authority's (RQIA) Review of the Operation of Health and Social Care Whistleblowing Arrangements[6]. The Model Policy, to be adopted by all HSC organisations in Northern Ireland, is set out at **ANNEX A**. HSC organisations may tailor the Model Policy to take account of their individual organisation's policies and procedures.

12. This Framework and Model Policy applies to **all staff** (employees, workers[7]) involved in the work of an HSC organisation. It does not apply to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by the HSC organisation or about issues relating to the provision of health and social care. These will be dealt with under the organisation's **HSC Complaints Procedure**.

[6] Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
[7] Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996

13. This Framework and Model Policy is for staff to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their personal position they must follow the local grievance procedure or policy for making a complaint about Bullying and/or Harassment.

14. All cases of suspected, attempted or actual fraud raised under this policy should be handled promptly in line with the organisation's **Fraud Response Plan.**

AIMS

14. The aim of this Framework and Model Policy is to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 a member of staff is able to raise legitimate concerns when they believe that a person's health may be endangered or have concerns about systematic failure, malpractice, misconduct or illegal practice without fear of retribution and/or detriment.

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15. If a member of staff has honest and reasonable suspicions about issues of malpractice/wrongdoing and raises these concerns through the channels outlined in the model policy, they will be protected from any disciplinary action and victimisation, (e.g. dismissal or any action short of dismissal such as being demoted or overlooked for promotion) simply because they have raised a concern under this policy.

16. This Framework and Model Policy aims to improve accountability and good governance within the organisation by assuring the workforce that it is safe to raise their concerns.

17. The benefits of encouraging staff to report concerns include[5]:
    - identifying wrongdoing as early as possible;
    - exposing weak or flawed processes and procedures which make the organisation vulnerable to loss, criticism or legal action;

- ensuring critical information gets to the right people who can deal with the concerns;
- avoiding financial loss and inefficiency;
- maintaining a positive corporate reputation;
- reducing the risks to the environment or the health and safety of employees or the wider community;
- improving accountability; and
- deterring staff from engaging in improper conduct.

KEY PRINCIPLES & VALUES

Distinction between grievance & whistleblowing concerns

18. Whistleblowing concerns generally relate to a risk, malpractice or wrongdoing that affects others, and may be something which adversely affects patients, the public, other staff or the organisation itself. A grievance differs from a whistleblowing concern as it is a personal complaint regarding an individual's own employment situation. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant. Grievances are addressed using the HSC Grievance Policy.

Raising a concern openly, confidentially, or anonymously

19. In many cases, the best way to raise a concern is to do so openly. Openness makes it easier for the organisation to assess the issue, work out how to investigate the matter, understand any motive and get more information. A worker raises a concern confidentially if they give their name on the condition that it is not revealed without their consent. If an organisation is asked not to disclose an individual’s identity, it will not do so without the individual’s consent unless required by law (for example, by the police). A worker raises a concern anonymously if they do not give their name at all. If this happens, it is best for the organisation to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed.

Clearly if no-one knows who provided the information, it is not possible to reassure or protect them.

Malicious claims & ulterior motives

20. There may be occasions when a concern is raised either with an ulterior motive or maliciously. In such a case, and as set out in the model policy at Annex A, the organisation cannot give the assurances and safeguards included in the policy to someone who is found to have maliciously raised a concern that they also know to be untrue. Such situations should be handled carefully. The starting point for any organisation is to look at the concern and examine whether there is any substance to it. Every concern should be treated as genuine, unless it is subsequently found not to be. However, if it is found that the individual has maliciously raised a concern that they know is untrue, disciplinary proceedings may be commenced against that individual.

LEGAL FRAMEWORK

21. The Public Interest Disclosure (Northern Ireland) Order 1998[8] (the Order), allows a worker to breach his duty as regards confidentiality towards his employer for the purpose of 'whistleblowing'. It was introduced in the interest of the public, to protect workers from detrimental treatment or victimisation from their employer if they raise a genuine concern, whether it is a risk to patients, financial malpractice, or other wrongdoing. These are called "qualifying disclosures". A "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following circumstances:

- where criminal activity or breach of civil law has occurred, is occurring, or is likely to occur;
- where a person has failed, is failing or is likely to fail to comply with any legal obligation he is subject to;
- where a miscarriage of justice has occurred, is occurring or is likely to occur

[8] The Public Interest Disclosure (Northern Ireland) Order 1998

- where the health and safety of any individual has been, is, or is likely to be endangered;
- where the environment has been, is being or is likely to be damaged;
- where information indicating evidence of one of the above circumstances is being or is likely to be deliberately concealed.

22. A qualifying disclosure is made by the worker:

- to his employer, or where the worker reasonably believes that the relevant failure relates solely or mainly to the conduct of a person other than his employer or any other matter for which a person other than his employer has legal responsibility, to that other person;
- to a legal adviser for the purpose of obtaining legal advice;
- to the Department of Health or the Minister for Health;
- to a person prescribed by an Order[9] made by the Department for the Economy for the purposes of Article 67F of the Employment Rights (Northern Ireland) Order 1996.[10] The worker should reasonably believe that the relevant failure falls within any description of matters in respect of which that person is so prescribed and that the information disclosed, and any allegation contained in it are substantially true.

23. If the worker makes a disclosure to a person other than his employer or to a person not noted above, it will be a qualifying disclosure in accordance with the Order provided the following conditions are met:

- the worker reasonably believes the information disclosed and any allegation contained within it are substantially true;
- the disclosure is not made for personal gain;
- the worker must act reasonably, taking into account the circumstances;

In addition one, or more, of the following conditions must be met:

- the worker reasonably believes he will suffer a detriment if he makes the disclosure to his employer; or

[9] Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014

[10] The Employment Rights (Northern Ireland) Order 1996 as amended by the Employment Act (Northern Ireland) 2016

- in the case where there is no prescribed person as noted above, the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer; or
- the worker has previously made the disclosure to his employer or a prescribed person.

24. In determining whether it is reasonable for the worker to make the disclosure, regard shall be had, in particular, to:

    - the identity of the person to whom the disclosure is made;
    - the seriousness of the relevant failure;
    - whether the conduct is continuing or likely to occur in the future;
    - whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person;
    - whether any previously made concern was acted upon;
    - whether the worker followed any procedure laid down by the employer.

25. It should be noted that a disclosure of information is not a qualifying disclosure if the person making the disclosure commits an offence by making it

26. The Order covers all workers including temporary agency staff, student nurses and student midwives, persons on training courses and independent contractors who are working for and supervised by a HSC organisation. It does not cover volunteers. It also makes it clear that any clause in a contract that purports to gag an individual from raising a concern that would have been protected under the Order is void.

HANDLING CONCERNS

27. To enable a whistleblowing policy to work in practice and to avoid unnecessary damage, it is important to ensure that policies authorise all staff, not just health and medical professionals, to raise a concern, and identify who they can contact.

28. Legal protection is very important if staff are to be encouraged to raise a concern about wrongdoing or malpractice. However, it is vital that employers develop an open culture that recognises the potential for staff to make a valuable contribution to the running of public services, and to the protection of the public interest.

29. Where an individual is subjected to a detriment by their employer for raising a concern or is dismissed in breach of the Order, they can bring a claim for compensation under the Order to an Industrial Tribunal.

30. Managers can lead by example, by being clear to staff as to what sort of behaviour is unacceptable, and by role modelling the appropriate behaviours themselves. They should encourage staff to ask them what is appropriate if they are unsure before - not after - the event. If wrongdoing or a potential risk to patient safety is found, it should be taken seriously and dealt with immediately.

IMPLEMENTING LOCAL POLICY

31. It is important that all HSC organisations are committed to the principles set out in their whistleblowing arrangements and can ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation. To achieve this, it is necessary to ensure buy-in and leadership from management, and Trade Union engagement.

32. Within each organisation, an appropriate senior manager should be appointed to take responsibility for ensuring implementation of the whistleblowing arrangements. This could be the clinical governance lead, the nursing or medical director, or responsible officer. HSC organisations should also consider appointing an appropriate number of advisors/advocates to signpost and provide support to those wishing to raise a concern. In addition, each organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.

33. As an employer, HSC organisations must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. Employers should consider a range of possibilities depending on the nature of each case[5]:
    - explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
    - minor concerns might be dealt with straightaway by line management
    - a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
    - there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
    - there may be a clear need for a formal investigation.

34. Having considered the options it is important that employers clearly document the rationale for the way forward. The HSC organisation's local policy should make it clear whose responsibility it is to decide on the approach to be adopted.

35. If necessary, the HSC organisation can also seek advice and guidance from the relevant prescribed person.

36. Once local arrangements are in place, it is important to ensure all staff are aware of them, and this can be achieved in a number of ways: through hard copy correspondence with staff, communication by email and/or via organisations' intranet sites, through team briefings and inductions, or the message appearing on payslips. It is also important to ensure that the policies are accessible.

BRIEFING & TRAINING

37. Many concerns will be raised openly with line managers as part of normal day-to-day practice. Good whistleblowing arrangements should do nothing to undermine this. It is important that this is made clear to both staff and managers.

38. All managers and designated contacts should be briefed on:

- the value and importance of an open and accountable workplace;
- how to handle concerns fairly and professionally;
- how to protect staff who raise a genuine concern and where staff can get help or refer a concern;
- how to manage expectations of confidentiality;
- the importance of an alternative to line management if the usual channels of communication are unavailable; and
- how to brief their staff on arrangements.

39. Senior managers and designated contacts who are given a specific role in the whistleblowing arrangements should receive training in the operation of their policy for raising concerns.

AUDIT, REVIEW & REFRESH

40. A well-run organisation will periodically review its whistleblowing arrangements to ensure they work effectively and that staff have confidence in them. The following points can sensibly be considered to assure the organisation that the arrangements meet best practice. Monitoring the arrangements in line with this checklist will also help the organisation demonstrate to regulators that their arrangements are working:

- arrange regular feedback sessions to evaluate progress and collect data on the nature and number of concerns raised;
- check the procedures used are adequate to track the actions taken in relation to concerns raised and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by whistleblowing. Is there evidence of constructive and timely feedback?
- have there been any difficulties with confidentiality?
- have any events come to the organisation’s attention that might indicate that a staff member has not been fairly treated as a result of raising a concern?

- look at significant adverse incidents/incident management systems or regulatory intervention - could the issues have been picked up or resolved earlier? If so, why weren't they?
- compare and correlate data with information from other risk management systems;
- find out what is happening on the ground - organisations should consider including a question about awareness and trust of arrangements in any future local staff surveys;
- organisations should seek the views of trade unions/professional organisations, as employees might have commented on the whistleblowing arrangements or sought their assistance on raising or pursuing a whistleblowing concern;
- organisations could also consider other sources of information, including information from exit interviews, the Order or other legal claims;
- key findings from a review or surveys should be communicated to staff. This will demonstrate that the organisation listens and is willing to learn and act on how its own arrangements are working in practice;
- refresh whistleblowing arrangements regularly. Regular communication to staff about revised arrangements is also recommended;
- although volunteers are not covered by the Order, the application of this Framework and Model Policy should be considered in the handling of their concerns; and
- think about reporting good news - success stories encourage and reassure everybody.

REPORTING & MONITORING

41. Concerns raised by staff are an important source of information for HSC organisations. It is important that they capture key aspects so that the value of their whistleblowing arrangements can be determined and lessons learned where appropriate.

42. In addition to individual case files HSC organisations should maintain a central register of all concerns raised, in a readily accessible format. Any system for

recording concerns should be proportionate, secure and accessible by the minimum necessary number of staff.

43. An analysis of whistleblowing caseload should be reported regularly to senior management and the HSC organisation's Audit Committee. In addition, an annual return on caseload, actions and outcomes should be made available to the Department of Health. These will help inform those charged with governance that arrangements in place for staff to raise concerns are operating satisfactorily or will highlight improvements that may be required. HSC organisations should consider reporting on the effectiveness of their whistleblowing arrangements in their annual report[5].

ANNEX A: MODEL POLICY

1. Introduction

All of us at one time or another may have concerns about what is happening at work. The [*name of HSC organisation*] wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or *[name of HSC organisation]* itself, it can be difficult to know what to do.

The [*name of HSC organisation*] recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof, raise the matter when it is still a concern. If something is troubling you of which you think we should know about or look into, please let us know. The [*name of HSC organisation*] has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

2. Aims and Objectives

[Name of HSC organisation] is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the [*name of HSC organisation*];
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the [*name of HSC organisation*] is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The *[Name of HSC organisation]* roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. Scope

The [*name of HSC organisation*] recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the [*name of HSC organisation*], including permanent, temporary and bank staff, staff in training working within the [*name of HSC organisation*], independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think *[name of HSC organisation]* should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the [*name of the HSC organisation's*] local grievance procedure or policy for making a complaint about Bullying and/or Harassment which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. Suspected Fraud

If your concern is about possible fraud or bribery [*name of HSC organisation*] has a number of avenues available to report your concern. These are included in more detail in the [*name of HSC organisation's*] Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Senior Manager
- Head of Department
- Director of Finance
- Fraud Liaison Office (FLO)

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The [*name of HSC organisation's*] Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the [*name of HSC organisation's*] or under its control. The [*name of HSC organisation*] expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5 *[Name of HSC organisation]* commitment to you

5.1 Your safety

The [*name of HSC organisation*], the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The [*name of HSC organisation*] will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The [*name of HSC organisation*] expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the [*name of HSC organisation*] reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the [*name of HSC organisation*] hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in [*name of Directorate and contact details*].

The [*name of HSC organisation*] is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for

example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice).

6. Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). But where you do not think it is appropriate to do this, you can use any of the options set out below.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

- the designated advisor/ advocate [insert details]
- the HR or Governance Team (whichever is appropriate) [insert details]

If you still remain concerned after this, you can contact:

- the [name] Director with responsibility for whistleblowing [insert details] or

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see paragraph 7 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. Raising a concern externally

The [*name of HSC organisation*] hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the [*name of HSC organisation*] would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the [*name of HSC organisation*] recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:
  - General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
  - The Regulation and Quality Improvement Authority;
  - The Health and Safety Executive;
  - Serious Fraud Office,
  - Her Majesty's Revenue and Customs,
  - Comptroller and Auditor General;
  - Information Commissioner
  - Northern Ireland Commissioner for Children and Young People
  - Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. The media

You may consider going to the media in respect of their concerns if you feel the [*name of HSC organisation*] has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The [*name of HSC organisation*] reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the [insert name of Department] on behalf of the [*name of HSC organisation*]. Staff approached by the media should direct the media to this department in the first instance.

9. Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the [*name of HSC organisation*] listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. Appendices

Appendix A – Roles and Responsibilities
Appendix B – Procedure
Appendix C – Advice for Managers

11. Equality, Human Rights & DDA

[The [*name of HSC organisation to confirm*] This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the [*name of HSC organisation*] to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.

The policy has been **screened out** without mitigation or an alternative policy proposed to be adopted.]

12. Personal & Public Involvement (PPI)/Consultation Process

[*name of HSC organisation to confirm*]

13. Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

14. Sources of advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

15. Policy Sign Off

Lead Policy Author	Date
Director of HR	Date

APPENDIX A

Roles and Responsibilities

The [name of HSC organisation]

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via organisations shared learning procedures

The non executive director (NED)

- To have responsibility for oversight of the culture of raising concerns within their organisation

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements

Managers

- To take any concerns reported to them seriously and consider them fully and fairly
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the [*name of HSC organisation*] where appropriate

- To invoke the formal procedure and ensure [*name of Directorate*] is informed, if the issue is appropriate
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations
- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns

This list is not intended to be exhaustive or restrictive

All Members of Staff

- To recognise that it is your duty to draw to the [*name of HSC organisation*] attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the [*name of HSC organisation*] and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

APPENDIX B

EXAMPLE PROCEDURE FOR RAISING A CONCERN

Step one (Informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager (lead clinician or tutor). This may be done verbally or in writing.

You are entitled to representation from a trade union/ fellow worker or companion to assist you in raising your concern.

Step two (informal)

If you feel unable to raise the matter with your Line Manager (lead clinician or tutor), for whatever reason, please raise the matter with our designated adviser/ advocate.

[name]

[contact details]

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the board any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

[name]

[contact]

Step four (formal)

You can raise your concerns formally with the external bodies listed at paragraph 7:

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and

properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of the [name of HSC organisation] to take forward the investigation in conjunction with the Agency if appropriate

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the [*name of HSC organisation*] Whistleblowing Policy.

Communicating with you

We welcome your concerns and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant professional Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

Board oversight

The [*name of HSC organisation*] board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a non-executive director with responsibility for the oversight of the organisation's culture of raising concerns.

Review & Reporting

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate.

We will provide regular reports to senior management and to our Audit Committee on our whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

APPENDIX C

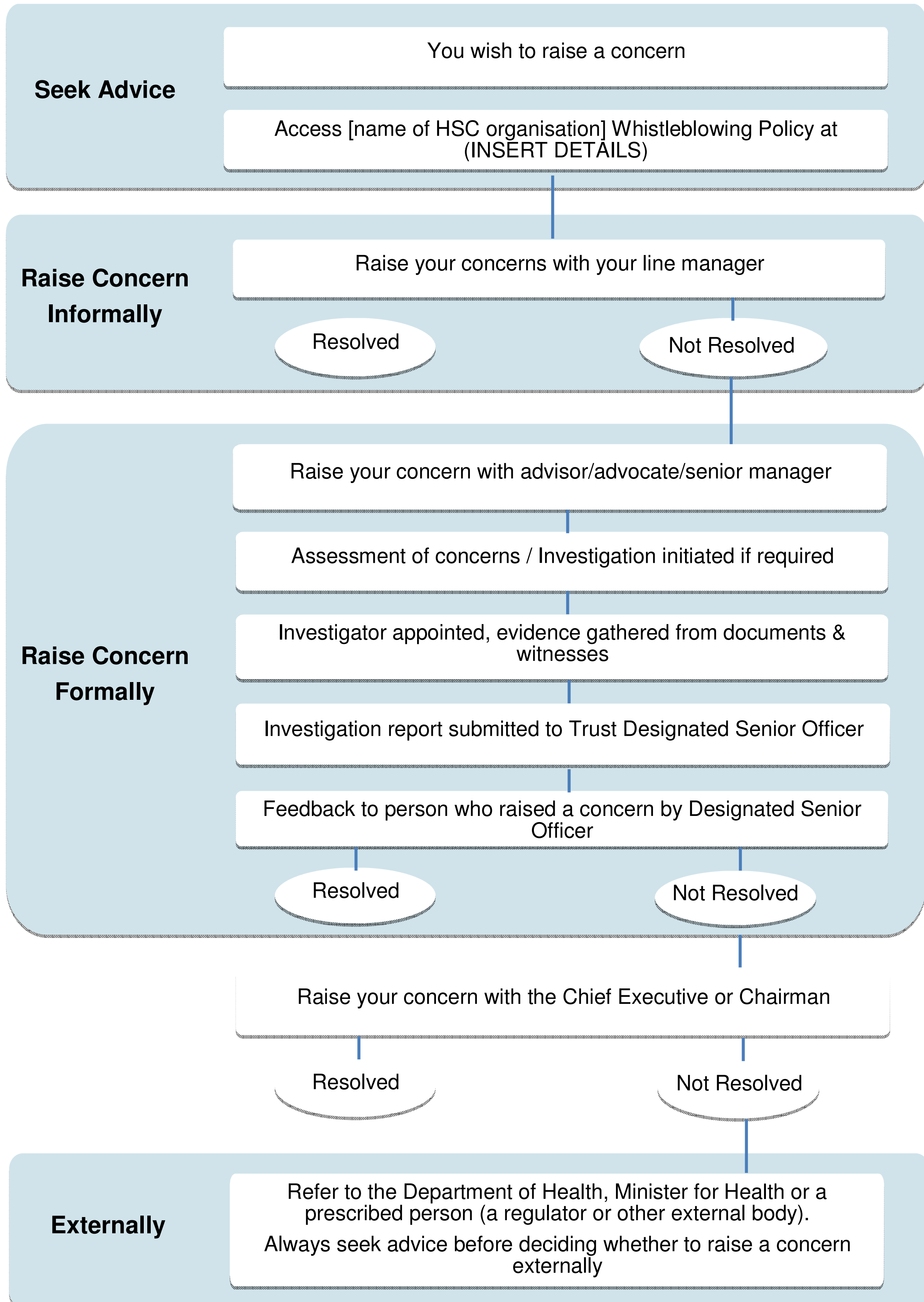
ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;
2. Respect and heed legitimate staff concerns about their own position or career;
3. Manage expectations and respect promises of confidentiality;
4. Discuss reasonable timeframes for feedback with the member of staff;
5. Remember there are different perspectives to every story;
6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;
7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);
8. Managers should bear in mind that they may have to explain how they have handled the concern;
9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;
10. Consider reporting to the board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed; and

11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary.

ANNEX B: FLOWCHART

Raising Concerns & Whistleblowing Process



Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

Independent report for the Secretary of State for Health

February 2015

Authors:
Kate Lampard
Ed Marsden

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1. Foreword

1.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the Department, and allegations that Savile committed sexual abuses on the hospitals' premises.

1.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites.

1.3 I have been supported by Ed Marsden, managing partner of Verita, a firm experienced in handling investigations in public sector and other organisations. This report describes our joint work and sets out our joint findings and recommendations. Our biographies can be found at appendix A. We are very grateful to Chloe Taylor, administrative assistant at Verita, for her help in organising our work.

1.4 We summarise in this report the findings of the reports of the NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

1.5 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

1.6 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Kate Lampard
February 2015

2. Introduction

2.1 An ITV Exposure programme broadcast in October 2012 involved allegations made by five women that Savile had sexually abused them. They said the abuse had taken place between 1968 and 1974 when they were teenagers. After the broadcast, the Metropolitan Police Service (MPS) took responsibility for assessing the claims it contained and invited others who had experienced abuse by Savile to report it to them. The MPS operation was given the name "Yewtree". Many hundreds of people have since made allegations and given evidence to Operation Yewtree about sexual abuse committed by Savile and others.

2.2 After the Exposure programme and the setting up of Operation Yewtree, reports surfaced of Savile having committed sexual abuses at the three NHS hospitals with which he had had long-term associations, namely Stoke Mandeville, Leeds General Infirmary and Broadmoor. In response, three major investigations were set up by the NHS trusts now responsible for the hospital sites in question (Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and West London Mental Health NHS Trust). The investigation relating to Broadmoor Hospital was jointly commissioned with the Department of Health as that department (previously the Department of Health and Social Security) had had direct management responsibility for Broadmoor at the time that Savile first became involved with the hospital and during a significant part of the time that he was associated with it. The terms of reference for the Stoke Mandeville investigation were in due course widened to encompass the Department of Health's part in Savile's relationship with that hospital too.

2.3 The Secretary of State for Health asked me in a letter dated 29 October 2012 (at page 124 in appendix B to this report) to provide independent oversight of the investigations being undertaken at Leeds General Infirmary, Stoke Mandeville and Broadmoor Hospitals and the Department of Health.

2.4 Once the scale of Savile's alleged activities at the three hospitals had become clearer and when concern about those activities was increasing, the Secretary of State for Health wrote to me again on 12 November 2012 (page 125 in appendix B to this report). His letter says:

> *"It is inevitable that as you sample and assure yourself that the processes the organisations have followed are robust, you will identify themes. I would*

therefore like to ask you to look too at NHS wide procedures in the light of the findings and recommendations of the reviews you are overseeing once they have been completed, seeking expert advice as necessary, and see whether they need to be tightened. If so, I would very much like you to advise me how any relevant guidelines or procedures need to be changed.

I am particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role."

2.5 I met the Secretary of State for Health in late November 2012 to discuss the work he had asked me to do in relation to Savile's associations with NHS organisations.

2.6 The MPS informed the Department of Health at the beginning of December 2012 about allegations that Savile had committed a single or possibly two sexual offences at other NHS hospitals besides Stoke Mandeville, Leeds General Infirmary and Broadmoor. The Secretary of State wrote to me on 6 December 2012 and asked me to ensure that my work on the themes emerging from the NHS investigations into Savile's activities and the lessons to be learnt for the NHS also took account of the conclusions of the investigations to be carried out in relation to these other hospitals.

2.7 After processing and reviewing further evidence and information held by the MPS and passed to the Department of Health at the end of 2013, investigations into allegations of abuses by Savile were set up at further NHS hospitals.

2.8 In a letter dated 15 November 2013 (page 129 of appendix B) the Secretary of State for Health asked me to provide him with general assurance of the quality of the reports resulting from all of the new investigations beyond those at Leeds General Infirmary, Stoke Mandeville and Broadmoor. The Secretary of State also asked that the report on lessons learnt should include any learning from the new investigations.

2.9 Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014.[1] Sixteen further investigation reports are being published on the same day as this report.

[1] The published reports can be viewed and downloaded via the following link: https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile

2.10 Allegations and information which came to light after June 2014 about Savile's presence on NHS premises were investigated by the relevant NHS trust, with oversight from the NHS Savile legacy unit. The chair of that unit, Dr Sue Proctor, advised me and Ed Marsden of any themes to emerge from those investigations. We have taken account of them in writing this report.

2.11 On the day of publication in June 2014 the Secretary of State made a statement to the House of Commons. Among other remarks about the outcomes of the investigations, he said:

> *"There are some painfully obvious lessons for the system as a whole. First, we must never give people the kind of access that Savile enjoyed to wards and patients without proper checks, whoever that person may be. Secondly, if people are abusive, staff should feel supported to challenge them, whoever that person may be, and take swift action. Thirdly, where patients report abuse, they need to be listened to, whatever their age, whatever their condition, and there needs to be proper investigation of what they report. It is deeply shocking that so few people felt that they could speak up and even more shocking that no one listened to those who did speak up. That is now changing in the NHS, but we have a long way to go.*
>
> *In ensuring appropriate measures, we must not hinder the extraordinary contribution of thousands of volunteers and fundraisers working in the NHS every day. They are the opposite of Savile and we need to ensure that their remarkable contribution is sustained."*

2.12 Ed Marsden and I reflect on these themes in this report.

3. Terms of reference

3.1 The terms of reference for the work described in this report were set out in the Secretary of State for Health's letter dated 12 November 2012 referred to above. They were to:

- identify the common themes from all the NHS investigation reports into matters relating to Jimmy Savile;
- look at NHS-wide guidelines and procedures in the light of the findings and recommendations of all the NHS investigation reports;
- seek relevant expert advice (if appropriate); and
- advise the Secretary of State for Health on whether and how any relevant guidelines or procedures need to be tightened or changed.

3.2 The Secretary of State for Health said he was particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role. He has expressed concern about whether or not current systems sufficiently safeguard patients.

4. Executive summary and recommendations

Executive summary

4.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the department, and allegations that Savile committed sexual abuses on the hospitals' premises.

4.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites. Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014. Sixteen further investigation reports are being published on the same day as this report.

4.3 I have been supported in my work by Ed Marsden, managing partner of the consultants Verita. In this report we summarise the findings of the reports of NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

4.4 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

4.5 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Methodology

4.6 During the course of our work we maintained close contact with the many NHS Savile investigation teams and with the NHS Savile legacy unit. We also had regular contact with MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process. We have drawn on the evidence and findings contained in all the investigation reports.

4.7 Our own evidence gathering included:

- meetings and interviews with commentators, experts and practitioners;
- a review of relevant documents, articles, research literature and reports;
- a call for evidence from NHS staff;
- a programme of hospital visits; and
- two discussion events (one with historians, described below, and one with experts in sexual offending and safeguarding).

Historical background

4.8 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy[2] to put on a discussion event for the NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons still relevant for today's NHS.

[2] History and Policy is a national network of academic historians.

Our findings

4.9 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- security and access arrangements, including celebrity and VIP access;
- the role and management of volunteers;
- safeguarding;
- raising complaints and concerns (by staff and patients);
- fundraising and charity governance; and
- observance of due process and good governance.

Security and access arrangements

4.10 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with what we learnt about how awareness of security and security arrangements elsewhere in the NHS have developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.

4.11 Hospitals should try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us however, that total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their "facility" and they have many and varied reasons for wanting access to it.

4.12 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years. He wandered freely about the hospital and had access to wards and clinical areas during the day and at night. The Stoke Mandeville

investigation report shows that the circumstances of Savile's access within that hospital were similar to those at Leeds General Infirmary.

4.13 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare. Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

4.14 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and of the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures.

Role and management of volunteers

4.15 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising for these and other NHS organisations.

4.16 We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

4.17 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded. Nearly all of the hospitals we had contact with told us they had plans to increase their volunteer numbers.

4.18 The scale of the volunteer presence and the extent and nature of the work they do means that the arrangements for managing volunteers, and the risks associated with their presence in hospitals, need to be robust and command public confidence.

4.19 Effective management of volunteers requires board level commitment and leadership. Organisations need to take a strategic approach to planning their volunteer schemes. Managing a scheme properly demands resources and has a cost.

4.20 The management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them. Some hospitals we visited demonstrated that their volunteer schemes were overseen at board level, were subject to strategic planning processes and that their voluntary service managers had appropriate support. However we also encountered hospital voluntary services that did not appear to be strategically planned or led, and where the voluntary services manager worked in isolation with little or no connection to the wider management system of the hospital, and with little or no management or adminstrative support.

4.21 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS).

4.22 Hospitals told us that they gave new volunteers induction training. In most cases the induction training included safeguarding training but it was not always of high quality. The training volunteers receive needs to impart the values of the organisation as a whole, and the expectations and responsibilities of volunteers, including the part they play in safeguarding patients, visitors and colleagues.

4.23 There is also an issue with hospitals not requiring volunteers to have their training updated and refreshed. Volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding isuues and respond to them appropriately.

4.24 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we

spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering.

Safeguarding

4.25 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In keeping with these wider societal developments, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. There is some concern however that while staff may be aware of the issues raised by recent scandals, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

4.26 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. We also learnt of hospitals that did not ensure that all staff updated their safeguarding training.

4.27 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. The numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding, but it is essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

4.28 We considered what makes for an effective safeguarding system from the particular perspective of trying to prevent a recurrence of events similar to the Savile case. We identified the need for hospital leadership that promotes the right values:

boards and individual leaders of organisations must be clear about their intention to take safeguarding seriously and put in place mechanisisms that allow concerns to be raised and dealt with properly. Effective safeguarding requires organisations to encourage openness and listening when people, including children, raise concerns. It also requires senior staff to be approachable and well informed about what is happening in their organisations: we heard of good examples of senior managers spending time on wards and how this allowed them to pick up on issues of concern.

4.29 It is an essential part of an effective safeguarding system that safeguarding messages are reinforced through regular training and communication with staff. As part of this, organisations also need to demonstrate and give feedback to staff to show that they respond appropriately to specific safeguarding concerns.

Specific safeguarding issues

DBS checking

4.30 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals.

4.31 The Discloure and Barring Service (DBS) maintains lists of people barred from engaging in “regulated activity”. An organisation engaging staff and volunteers in “regulated activity” can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check. It is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is “regulated activity” as defined by Safegauarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).[3]

4.32 In the context of NHS hospital settings, what amounts to “regulated activity” in relation to adults differs significantly from that relating to children. With adults, only

[3] An organisation engaging staff and volunteers not in “regulated activity” can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible for such checks because of their activities. This includes work or volunteering with vulnerable groups including children.

those staff or volunteers with direct hands-on or close contact with adult patients can be required to undergo a barring list check, and this applies whether they undertake the activity in question once or more frequently, and whether or not they are supervised in it. With respect to children, staff and volunteers with less intimate contact can be required to undergo a barring list check but checks can only be required where the activity in question is undertaken frequently and is unsupervised.

4.33 Most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring list checks for staff and volunteers working in NHS hospital settings and elsewhere and the risks this poses. Many staff and volunteers in NHS hospitals who do not fall within the present definitions of "regulated activity" have legitimate reasons and opportunities for being in close proximity to adult and child patients and their visitors. The concerns are compounded by the fact that people in hospital are more vulnerable and likely to be at greater risk than others from the attentions of those inclined to commit sexual assault.

4.34 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital. Nevertheless we believe it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients or their visitors to be subject to barring list checks.

4.35 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. It is naïve to assume that a risk based approach, rather than mandatory periodic checks, offers greater assurance in relation to record checking. Large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. We believe there should be DBS checks on NHS hospital staff and volunteers every three years.

NHS engagement with wider safeguarding systems

4.36 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements.

4.37 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations to make referrals to the local authority desginated officer (LADO) and to the Disclosure and Barring Service (DBS) in respect of staff who had harmed or posed a risk of harm to children or adults vulnerable to abuse.

4.38 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Internet and social media access

4.39 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care, particularly children and young people, from the risks posed by modern information technology.

4.40 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy, to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful.

The management of human resources

4.41 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. A number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact

follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training.

4.42 The Leeds investigation, and our own investigations, showed that in some hospitals responsibility for certain employment and human resources matters lies elsewhere than with the hospital's HR department. For instance, some contract staff are managed by facilities and estates departments. Recruitment, checking and training of staff including contract and agency staff should be managed professionally and consistently across a hospital trust. HR processes expected of third party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers. Overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director.

Raising complaints and concerns

4.43 The difficulties that Savile's victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations.

4.44 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them. We identified a number of specific matters, set out below, that we believe will encourage staff, patients and others to raise the alarm about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

4.45 Many people we interviewed told us that the term 'whistleblowing' to cover policies aimed at encouraging staff and others to speak out about matters of concern was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised.

4.46 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term 'whistleblowing' and had changed the name of their policy to 'raising concerns policy' or were using the term 'raising concerns' in conjunction with 'whistleblowing'. All NHS organisations should ensure that the title and content of their policy make clear that it applies to raising all concerns, whether or not they amount to matters some might describe as 'whistleblowing'.

4.47 Staff should also be trained and encouraged to report any matters which indicate a risk of harm to others even if such matters appear to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

4.48 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns. It is important in encouraging hospital staff to overcome or question the behaviour of others that managers are present within the hospital and approachable. Managers need to be trained to deal positively and appropriately when matters of concern are reported to them.

4.49 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so.

4.50 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had improved markedly in recent times.

Providing opportunities for staff, patients and others to raise concerns

4.51 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. All organisations must continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients.

Mandatory reporting

4.52 Mandatory reporting of information and suspicions relating to abuse is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal.

Fundraising and charity governance

4.53 The Savile case raises the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in fundraising for NHS organisations.

4.54 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. They are governed by the NHS Act 2006 as well as charity law. In most cases the hospital's board acts collectively as trustee of the charitable property given to it.

4.55 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate

trustee of their charitable funds established and regulated under NHS legislation if they wish to do so.

4.56 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. Many individual charitable trusts, like those established by Savile, raise funds for NHS organisations but sit outside the governance arrangements of the NHS.

4.57 We considered how NHS hospitals and their associated NHS charities ensure that their fundraising is subject to good governance, and how they ensure appropriate management of their relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

4.58 The first element of best practice in charitable fundraising is proper risk management to ensure not only the protection of charitable assets and funds raised but also the good name and reputation of the charity. In considering the risks to an NHS charity and the organisation it seeks to benefit, trustees and hospital managers must look at the hospital's and the charity's relationships with celebrities, major donors, commercial partners and other charitable organisations.

4.59 Most of the NHS organisations we had contact with did not have clear documented policies and risk assessment processes for managing these relationships and for protecting the organisation's brand and reputation. Some said they had no need of formal arrangements because of the limited nature of their fundraising activity. However we believe that staff with little or no experience of managing relationships with celebrities and major donors are at greatest risk of being "star struck" and of mishandling such relationships. They must be able to refer to guidance in a formal policy.

4.60 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent.

4.61 Best practice also requires NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes, with no

one trustee or group of trustees dominating decision making or acting other than in the interests of the charity. There needs to be a shared understanding between hospital management and the NHS charity of the service needs and priorities of the hospital. This demands good communication and constructive behaviours.

The observance of due process and good governance

4.62 Savile's involvement with Broadmoor and Stoke Mandeville hospitals was supported and facilitated by government ministers and senior civil servants. It is not within our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

4.63 We make recommendations in this report aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. Ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations. They should not undermine the processes of good governance and local management.

Recommendations

Our recommendations for NHS hospital trusts are also addressed to Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts. Most of them are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of childen and adults.

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and
- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

5. Methodology

5.1 Throughout our work overseeing and assuring the thoroughness of the investigations at Leeds General Infirmary, Stoke Mandeville and Broadmoor and other NHS hospitals (which is described in detail in the assurance report published on 26 June 2014) we maintained close contact with the investigation teams. We also had regular contact with the NHS Savile legacy unit and with the MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process.

The issues

5.2 The issues and themes that we felt we needed to investigate and take evidence about in order to fulfil our terms of reference are broadly:

- hospital security and access arrangements;
- NHS organisations' associations with celebrities, including the privileges and access accorded to them;
- the role and management of volunteers in NHS hospitals;
- safeguarding in hospital settings;
- raising complaints and concerns;
- fundraising and charity governance in the NHS; and
- observance of due process and good governance.

5.3 These issues formed the basis of the evidence-gathering we undertook over about 20 months commencing in January 2013.

Evidence gathering

5.4 Our evidence-gathering included meetings and interviews with commentators, experts and practitioners; a review of documents, articles, research literature and reports; a call for evidence from NHS staff; and a programme of hospital visits. We commissioned a discussion event with eight historians to look at the historical context of Savile's behaviour, and another discussion event with experts in sexual offending and

safeguarding to consider the nature of Savile's behaviour and how the risks of such behaviour should best be managed.

Interviews

5.5 We began our evidence-gathering with a series of meetings and discussions with agencies, organisations or individuals we had identified as able to give us a general understanding of the behaviour of Savile and his activities in the NHS and the requirements of effective safeguarding systems. Among this group were Peter Davis, (now former) chief executive of the Child Exploitation and Online Protection Centre and Donald Findlater, director of research and development at the Lucy Faithfull Foundation, a charity working to prevent child sex abuse. Both discussed with us the profile and methods of those who seek to sexually abuse children and what society and organisations can do to minimise the risks they pose. We also met with experts in safeguarding children and vulnerable adults, including the independent chairs of a number of local safeguarding boards and representatives of the Association of Directors of Social Services. We met with others who could tell us about specific issues. In this category were representatives from NHS Employers, who told us about recommended policy and guidance for the safe recruitment and management of staff; the chief executive and director general of the Royal College of Nursing; representatives of the Patients Association and of various groups representing the interests of particular groups of patients such as Mencap and Age UK; the chair and chief executive of the Association of NHS Charities; senior managers from the Disclosure and Barring Service; representatives of the National Council for Voluntary Organisations. A full list of those who gave us interviews is at appendix C.

5.6 We met or spoke with a number of individuals, agencies and representatives of organisations who have undertaken their own reviews or investigations into issues relating to Savile's activities. They included representatives of Her Majesty's Inspectorate of Constabulary, who in March 2013 published a report into the knowledge that police forces had of historical allegations against Savile and their responses to them[4]; the Crown Prosecution Service, who undertook a review early in 2013 of the guidance issued on the investigation and prosecution of child sex abuse cases[5]; the secretariat supporting Rt Hon

[4] HMIC (March 2013) *Mistakes Were Made, HMIC's review of allegations and intelligence material concerning Jimmy Savile between 1964 and 2012.*
[5] Crown Prosecution Service (October 2013) *Guidelines on Prosecuting Cases of Child Sexual Abuse.*

Ann Clwyd MP and Professor Tricia Hart's review of the NHS complaints system[6]; the chair of the "Institutions" work stream of the National Group on Sexual Violence against Children and Vulnerable Adults; the Parliamentary and Health Service Ombudsman; and Sir Robert Francis QC[7].

Call for evidence

5.7 We wrote on 2 May 2013 to the chairs and chief executives of all NHS hospital trusts and all clinical commissioning groups and local authorities in England to make a general call for evidence from staff about the matters and issues we were investigating. Our letter, reproduced at appendix D to this report, gave a dedicated email address staff could use to send us their evidence and comments.

5.8 Eighty-three organisations or individuals responded to our call for evidence and they are listed in appendix E. Most of the respondents either gave a narrative account of their organisation's current practices and procedures or sent us copies of their policy documents relating to the issues we had raised in our letter. Two respondents raised matters they wished to speak to us about directly and we made arrangements to interview them by phone or in person.

Document review

5.9 In addition to documentary evidence, mostly in the form of written policies, sent to us in response to the call for evidence or given to us on our visits to NHS hospitals described below, we reviewed other guidance documents, reports, research literature, and articles. A list of these is set out at appendix F.

[6] Rt.Hon. Ann Clwyd MP and Professor Tricia Hart (October 2013) *Putting Patients Back in the Picture: A review of the NHS Hospitals Complaints System.*
[7] Robert Francis QC (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Sir Robert Francis QC (February 2015) *Freedom to Speak Up; An independent review into creating an open and honest reporting culture in the NHS.*

Hospital visits

5.10 The hospital trusts we visited as part of our evidence-gathering were chosen to represent the spread of NHS hospitals in size, location, type of service offered, reputation and governance structure. We therefore visited a London teaching hospital, district general hospitals and specialist hospitals, (including a children's hospital and a mental health trust), foundation trust hospitals and hospital trusts that have not yet achieved foundation trust status. A list of the hospitals we visited is at appendix G.

5.11 Each visit took place over one or two full days and included a series of planned interviews with directors, managers and staff with governance and operational responsibility for the matters we needed to consider such as security, safeguarding, associations with celebrities, processes for making complaints and raising concerns and fundraising. Our visits also included tours of wards and other parts of the hospitals during which we talked informally to frontline staff about their experiences and views and saw for ourselves how policies and procedures translated into practice. We also made shorter visits to two other hospitals to conduct interviews about their volunteer programmes.

5.12 All the planned interviews we undertook were recorded and transcribed. We told interviewees we might name them and/or quote from their transcript in this report. Interviewees were given a draft copy of the transcript of their interview for their comments and approval.

Further evidence gathering

5.13 To help the NHS investigation teams and to inform our work on the lessons learnt, we commissioned History and Policy[8], a collaboration between King's College London and the University of Cambridge, to put on a discussion event. Eight historians from across the country with relevant expertise considered with us the historical background to Savile's offending and his association with NHS organisations and its significance in identifying lessons for today's NHS. The details of that event are described in section 7 below.

[8] History and Policy is a national network of some 500 academic historians and publishes historical research to demonstrate the relevance of history to contemporary policy making.

5.14 We organised a further discussion event with a number of experts in sexual offending, safeguarding and crime prevention to consider the nature of Savile's behaviour, and how best to manage the risks people like him pose. We also discussed and tested with them the findings and recommendations emerging from our work.

5.15 In addition to the evidence gathered in the way we describe above, as required by our terms of reference, this report also relies on the findings set out in the reports of Savile investigations by individual NHS hospitals. They are listed at appendix H.

The limitations of our investigations

5.16 We confined ourselves to learning lessons for and evaluating present arrangements in NHS hospitals: we have not considered arrangements in other types of settings or organisations. However most of our recommendations, although addressed principally to NHS hospital trust boards, are relevant to other hospital and care providers.

5.17 The hospitals we visited represented only a small sample of NHS hospitals but they were situated in different parts of the country and covered as wide a spectrum as possible.

5.18 Our hospital visits were supplemented by evidence received from hospital trusts in response to our call for evidence. Perhaps inevitably, those hospitals that answered the call for evidence and volunteered information mostly described their present arrangements in positive terms and suggested a high degree of awareness of the issues we asked them about, particularly general safeguarding issues. In order to redress the balance we deliberately identified and visited a couple of district general hospitals that had not responded to our call for evidence and would be described in NHS circles as "challenged".

5.19 Our visits and the information supplied under the call for evidence or gathered elsewhere made clear there is disparity between organisations with regard to their awareness of the issues thrown up by the Savile case as well as the policies, procedures and resources they have to manage those issues. Some organisations - such as the children's hospital we visited - demonstrated greater awareness of and commitment to safeguarding children than was the case in other organisations. But it needs to be

remembered that Savile's activities took place in a teaching hospital, district general hospitals and a secure hospital: all hospital organisations must understand the risks they face and mitigate them appropriately. We use this report to highlight good practice as well as the risks and weaknesses we have identified as a result of our evidence-gathering. We hope all hospitals, regardless of their specialism or other particular features of their work, will use this report to inform a critical self-analysis of their procedures.

5.20 Some issues arising from the Savile affair and relevant to NHS hospital settings have been the subject of recent investigations and reports by other people and organisations.[9] Where this is the case, we contacted them in order to understand the parameters of their work and avoid duplication. Where pertinent to do so we refer to and rely on their work.

The naming of NHS trusts and witnesses

5.21 We visited only a small sample of NHS hospitals, chosen because they represented different types of NHS hospital in different places. The staff we interviewed formally or spoke to on visits to wards and other clinical areas were helpful and generous with their time. They gave their answers in a thoughtful and open way.

5.22 In these circumstances we think it would be unfair and inappropriate to name hospitals whose policies or practices we criticise. For the same reasons we do not identify witnesses whose evidence might attract personal criticism. Where we had concerns about the policies and practices of the hospitals we visited we discussed them with the management of the organisation.

[9] For example, the recent review of the NHS hospital complaints system by Rt. Hon. Ann Clwyd MP and Professor Tricia Hart (October 2013) *Putting Patients Back in the Picture: A review of the NHS Hospitals Complaints System*.

6. Findings of the NHS investigations

6.1 In this section we give a broad outline of the findings and themes of the NHS investigations into matters relating to Savile. These findings and themes have informed our own investigations and our consideration of the lessons for NHS hospitals today. The reader should refer to the individual NHS investigation reports[10] for a more complete account of their findings, especially in relation to issues that are specific to a particular hospital.

6.2 Savile first gained entry and a foothold in the three main hospitals with which he was associated, Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals, ("the three main hospitals"), by undertaking voluntary work. At Leeds General Infirmary this was initially by helping with the hospital radio service and he then went on to work as a volunteer porter, a role he subsequently also undertook at Stoke Mandeville. At Broadmoor he was initially invited to help put on entertainments. Savile became a regular presence at each of the three main hospitals over many years - in the case of Leeds General Infirmary, for over 50 years. Savile was a significant fundraiser for a number of projects at Leeds General Infirmary. In 1981 at the instigation of a government minister he was given responsibility for overseeing the £10m fundraising campaign for the development of Stoke Mandeville's National Spinal Injuries Centre (NSIC). He was also given effective control of the building project for the centre, which was completed in 1983.

6.3 Savile visited many other NHS hospitals across the country, mostly on a one-off basis. He made these visits in his capacity as a celebrity to attend fundraising, prize-giving, and broadcasting events.

6.4 Savile's involvement with the three main hospitals was encouraged and supported by senior hospital and NHS managers. In the case of Leeds General Infirmary and Broadmoor, his volunteer roles were expressly sanctioned at the highest level within those hospitals. Managers appear to have taken a positive view of his presence. They welcomed an association with a significant celebrity who could raise the profile of their hospital and

[10] The reports can be accessed via the following link:
https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile

might boost staff and patient morale. In due course, managers at Leeds General Infirmary and Stoke Mandeville came to appreciate and rely on his fundraising capabilities. In turn, Savile used the publicity surrounding his involvement with the hospitals and his fundraising on their behalf to gain publicity for himself and to enhance his celebrity status.

6.5 Successive management teams at the three main hospitals appear not to have questioned or assessed the risks associated with Savile's role and presence in their organisation. The NHS investigations found no evidence of any arrangements to manage or define Savile's work or his relationships with the hospitals.

6.6 The investigation reports show that security arrangements at hospitals during Savile's time were less sophisticated than they are today. Hospitals appear to have had little or no formal policy governing access by visitors and others, including celebrity visitors, on hospital premises. At each of the three main hospitals Savile had access to keys and virtually unfettered access to all parts of the hospitals including wards, and other clinical and restricted areas. At Broadmoor, a high-security mental health hospital, Savile was given his own set of keys which gave him access to ward areas, day rooms and patients rooms and he was able to reach some patient areas without supervision. At Leeds General Infirmary Savile also had the privileges of a parking space and a series of offices. At Stoke Mandeville Savile initially slept in a camper van he was allowed to park in the hospital grounds but at some stage he was given accommodation with shared facilities alongside female hospital students. At Broadmoor he had his own accommodation outside the secure perimeter of the hospital but he was able to park his camper van within the secure perimeter.

6.7 The findings we set out above indicated the need for us to examine hospital security and access arrangements, including in relation to celebrity and VIP volunteers and visitors, and the role and management of volunteers in NHS hospitals.

6.8 Officials in the Department of Health and Social Security (as it then was) acting on the wishes of government ministers put in place arrangements under which Savile became chairman of the trustees of the appeal for the development of the NSIC at Stoke Mandeville. The trustees were in effect given total control over the building development project as well as fundraising for it, and statutory and other frameworks relating to management of such a project were swept aside. In 1987, the department, which had direct management responsibility for Broadmoor, appointed Savile as a non-executive

director of the hospital board. The next year the department appointed Savile to head a task force to run Broadmoor until the establishment of a new Special Hospitals Service Authority (SHSA) in the following year. As head of the task force, Savile influenced the appointment of a friend of his to the post of the SHSA's general manager at Broadmoor. The positions granted to Savile strengthened the impression he gave to staff and managers at all the hospitals with which he was involved that he was close to government ministers, Department of Health officials and other influential people and that he was in a position of authority.

6.9 These findings raised questions about governance arrangements in NHS hospitals, particularly in relation to charity fundraising, and the role played by central government in undermining statutory or conventional governance processes and procedures.

6.10 Savile's public behaviour towards women both patients and hospital staff, was attention seeking and inappropriate. It included lewd remarks and theatrical hand and arm kissing. His behaviour in ward and clinical areas at the three main hospitals was loud and disruptive. While some staff accepted Savile's behaviour as *"just Jimmy"* and valued his fundraising and support for their hospital, many disliked him and viewed him as a nuisance, a *"creep"* and a promiscuous sex pest.

6.11 Savile's access and influence in NHS hospitals gave him opportunities to commit sexual assaults. Most of the assaults were opportunistic but some included an element of premeditation, including grooming. Some assaults were facilitated by other people. Savile's known victims ranged in age from five to 75. They included men and women, patients, staff and hospital visitors. Most victims did not tell anyone what had happened to them. Among the reasons given for this were that they thought they would not be believed because of Savile's celebrity and status in the hospital; they felt embarrassed or humiliated; they believed they would not be taken seriously; they thought they were in some way to blame; they thought it was not important enough to be reported; they had been intimidated by threats from Savile; or they feared repercussions.

6.12 A few of Savile's victims did report what had happened to them to members of staff, their relations or to senior colleagues. Mostly those reports were either not believed or were brushed aside or ignored.

6.13 During Savile's time, policies and procedures for safeguarding patients and others and internal controls for managing the behaviours of certain staff groups were lacking or deficient. At Broadmoor, there was *"an atmosphere within the hospital that tolerated inappropriate behaviour, including sexual misbehavior, and that discouraged reporting"*[11].

6.14 The NHS investigations found no evidence that the rumours and talk about Savile's generally inappropriate behaviour or specific reports of sexual assaults by him were ever escalated or otherwise came to the attention of senior managers. The investigation reports in part attribute this to the fact that in Savile's time hospitals were hierarchical institutions and that wards and departments tended to work in "silos", taking responsibility for managing their own affairs. Nevertheless, the Leeds General Infirmary and Stoke Mandeville Hospital investigation reports criticise senior managers for not questioning Savile's role in their hospitals and ensuring that he was adequately managed and supervised. Senior managers are also criticised for the fact that systems and processes in their hospitals were not robust enough to ensure that concerns and complaints about Savile's behaviour were escalated to them and dealt with appropriately.

6.15 The findings about Savile's behaviour and his sexual assaults indicated the need for us to examine safeguarding arrangements in NHS hospitals, the raising of complaints and matters of concern and how managers and staff respond to complaints and matters of concern.

[11] Broadmoor investigation report, para. 1.26

7. Historical background

7.1 We are conscious of the historical nature of the events the investigation teams looked into and the challenges this presents in drawing the right lessons for the NHS of today. Savile first started volunteering in hospital radio at Leeds General Infirmary in 1960. He was a volunteer either at that hospital, or at Stoke Mandeville or Broadmoor over the next 50 years. The earliest known incident of offending by Savile on NHS premises took place at Leeds General Infirmary in 1962. The last such incident we know of was also at Leeds General Infirmary in 2009.

7.2 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy to put on a discussion event for the main NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons that today's NHS should draw from the Savile affair.

7.3 At the History and Policy event we received presentations from and held discussions with eight historians from across the country. Their expertise covers the culture and issues that formed the background to Savile's life, his work in the NHS and his offending on NHS premises. Among the topics aired with us were: the changing sexual culture in the period in question; attitudes (including in the press) to celebrity and privacy; the legal status of and attitudes to victims of child sex abuse; charitable fundraising and volunteering in the NHS; NHS management structures and culture in the relevant period.

7.4 We will not attempt to summarise all the evidence and analysis presented to us by the contributors to the History and Policy event[12]. We think it would be helpful however to set out some of the "headline" findings and messages that we took from the event, and which informed our consideration of how Savile was able to behave as he did and the implications for present day arrangements in NHS hospitals.

[12] The presentation slides and supporting materials provided to us at the History and Policy event can be downloaded at http://www.historyandpolicy.org/consultations/consultations/jimmy-savile-investigations

7.5 Adrian Bingham, (reader in modern history, University of Sheffield), described to us the significant change in the sexual culture during the 1960s and 1970s. This was attributable to a number of factors, among them the liberalisation of media censorship and regulatory regimes, an expansion in youth culture and its economic prominence, and the availability of the pill. The pop music world was one of the most sexually liberated milieus. We were given evidence that some prominent figures within it demonstrated little or no regard for the sexual vulnerability of the young music fans they encountered.

7.6 The British press became increasingly intrusive from the late 1950s. Nevertheless, libel laws meant the press were still disinclined to take risks in exposing scandalous behaviour by well-known or wealthy people such as Savile. We were referred to the inhibiting effect on the press of the Sunday Mirror's reporting of the affairs of Lord Boothby in 1964, which resulted in the payment of £40,000 (an enormous sum) and the sacking of the paper's editor. The cautious attitude of the press prevailed until the 1980s when intense tabloid competition spurred editors into taking greater risks. The Sun and the News of the World began regularly to print 'kiss and tell' exposés and stories. But contemporary reports suggested that Savile had a reputation for being quick to threaten to sue any newspaper that wrote disobliging things about him. Two national newspaper editors have said they were prevented by their papers' lawyers from publishing credible evidence of Savile's crimes.

7.7 Adrian Bingham identified two further reasons for the failure of the press to expose Savile's behaviour. First, music journalists *"shared a sense of fraternity with the stars they mixed with"* and feared that they would be denied future access if they reported too much of what went on behind the scenes. Second, at least until the 1990s newsrooms were dominated by men. Sex scandals were viewed and reported on in terms of sexual titillation rather than the exposure of abuse.[13]

7.8 In relation to attitudes to the sexual abuse of women and children, Louise Jackson (reader in modern social history, University of Edinburgh), referred us to the fact that the Criminal Law Amendment Act 1885 raised the age of consent to 16 and made it an offence to have sex with a female under that age but until the present day, courts have been reluctant to believe and convict on the evidence of older child victims of sexual abuse. Dr

[13] See Bingham, A. (June 2014) *How did he get away with so much for so long? : The press and Jimmy Savile*. Opinion Article, www.historyandpolicy.org

Lucy Delap, (reader in 20th century history and director, History and Policy, King's College, London) pointed out that little attention was paid to sexual abuse as a component of child abuse until the 1970s. She also drew our attention to the fact that, although there was greater awareness in society during the 1980s of the concept of 'sexual harassment', with some resulting changes in legislation, the sexual culture of the workplace and other institutions did not change to any significant degree until the present century.

7.9 On the subject of volunteering and fundraising in the NHS we heard from Dr Martin Gorsky (senior lecturer in the history of public health at the London School of Hygiene and Tropical Medicine) and Professor John Mohan (professor of social policy and deputy director, The Third Sector Research Centre, University of Southampton). We heard about the long tradition of according status and respect to high-profile charitable givers to hospitals and the acceptance of volunteers on hospital premises, and how this continued even after the establishment of the state-funded NHS in 1948. Until the 1980s however restrictions applied to NHS hospitals wanting to use charitable funds and direct fundraising was forbidden. From the 1980s a tighter economic climate and low capital investment in the NHS, as well as a change in the social policy environment, resulted in a greater emphasis on voluntary effort. The Health Services Act 1980 enabled health authorities to engage directly in fundraising and to use public funds to do so. The appeal to fund much-needed building works at Stoke Mandeville Hospital began in 1979 and was spearheaded by Savile. It was the first and most prominent symbol of this new attitude to fundraising. The significance of the £10m the appeal raised over three years is illustrated by setting that sum against the £40m that was the annual capital budget for the entire Oxfordshire Regional Health Authority area (in which Stoke Mandeville was located).

7.10 Dr Stephanie Snow (senior research associate, Centre for the History of Science, Technology and Medicine, University of Manchester) described for us the management structures created for the NHS in 1948, which meant that hospitals were managed by a triumvirate of a hospital secretary, a medical administrator and a matron. This reinforced existing tensions and inequalities between lay, medical and nursing authority, with medical authority overriding that of nurses and administrators. Reforms in 1974 led to greater consensus in management but the concept of general management was introduced only in 1983. It significantly increased perceptions of the legitimacy of managers' control over clinical services. The introduction of the internal market in the late 1980s and early 1990s further strengthened the role of management.

7.11 Dr Alex Mold (lecturer in history, London School of Hygiene and Tropical Medicine) considered with us the arrangements for raising complaints in the NHS. Making complaints about NHS services is now much more common than even in the recent past, with 107,259 written complaints to hospitals in 2011/12 as against 9,614 in 1971. Throughout the period that Savile was associated with the NHS complaints systems were variable and problematic. The evidence suggests that this continues to be the case. There has never been a formalised NHS-wide system for managing complaints made by staff.

7.12 The contributors to the History and Policy event told us that particular historical circumstances played into the hands of Savile and would have helped him to avoid being caught. His status and influence as a high-profile celebrity and effective fundraiser, when set against relatively weak and fragmented local management structures would have given him power in NHS organisations and some protection from criticism and doubts about his behaviour. The media world, which was smaller, less intrusive, and more restrained in Savile's day than it is now, was less likely to expose concerns about his behaviour. And a reluctance of individuals to raise allegations of sexual abuse would have been compounded by weak NHS complaints handling systems and the shortcomings in the criminal justice system in dealing with cases of sexual abuse. The unsympathetic social culture in the workplace and hierarchal structures would also have deterred employees from complaining about having been abused.

7.13 Some of the historical cultural issues and circumstances we believe gave succour to Savile's abusive behaviour in NHS hospitals are perhaps of less relevance in the more open, sexually aware and more questioning culture of today. Our consideration of the historical context of the Savile case, the evidence we gathered from the NHS as well as the awareness-raising effect of the Savile case and other cases, lead us to think that NHS organisations, now managed by individual hospital trusts and subject to greater public scrutiny, are more conscious of good governance and security concerns. We believe they would be less likely to allow a celebrity or any outside individual to gain as much power, influence and access in the organisation as Savile did. Moreover, once an allegation of sexual abuse or inappropriate behaviour on hospital premises has been aired, our investigations suggest it is now more likely to be escalated and dealt with through formal channels. We also think chances are greater that the press and media of today would look into and expose someone like Savile, whose behaviour had been the subject of rumour and conjecture for some time.

7.14 But it would be foolish to suggest that all the circumstances that allowed Savile to act as he did have been swept away over time and that all safeguards against a future Savile are now in place. Society needs to be constantly vigilant and aware of the fact that those with paedophile or deviant tendencies will seek access to and work with children and the vulnerable. Rules and procedures aimed at mitigating risks to children and vulnerable groups need to be in place at all times. Society as a whole and individual organisations still need to focus on how sexual abuse is aired or identified in the first place and how allegations of sexual abuse are investigated and prosecuted through the criminal justice system. How the NHS supports people to raise complaints and how these are handled are still matters of concern. And concerns also exist about whether NHS volunteers, celebrities, and charitable fundraisers are properly managed and whether charitable funds are subject to appropriate governance arrangements.

8. Our understanding of Savile's behaviour and the risks faced by NHS hospitals today

8.1 In order to identify lessons from the Savile affair we considered the psychological characteristics, the behaviours and motives of Savile and others who commit sexual abuses and the extent of the risks they pose. We drew on limited evidence from Savile's family and others who encountered him. We also conducted individual interviews with experts in sexual offending and safeguarding. In addition, we brought together a number of such experts for a discussion event that explored the psychological profiles and offending behaviour of Savile and other sex offenders and how the risks of sexual abuse should best be managed.

8.2 Those who attended the discussion event are named in appendix J. They commented on some of the measures that should be in place to mitigate the risks of abuse in hospitals. Their comments and observations are included in later sections of this report.

8.3 We interviewed two members of Savile's family but they offered us little insight into his personality and motivations. Savile's nephew told us he *"loved the ground* [his mother] *walked on".* Savile nearly died as a child and this cemented the relationship between him and his mother. According to Savile's nephew, Savile's inclination to undertake charity work was inspired by his parents who *"did a lot for charity and because he was a devout catholic".*

8.4 A number of staff witnesses in the Broadmoor investigation described Savile's personality and general, public behaviour. The investigation report sets out their evidence as follows:

> *"Savile could, we were told, undoubtedly be charming, persuasive and oddly charismatic, at least to some people, although others found him* "a showman", "bombastic", "charmless" *or* "arrogant"*. He was self-centred, narcissistic and grandiose, talking only about himself, his achievements (real or imagined) and the 'people in high places' he knew. He was described to us as extremely manipulative but lacking in warmth or human empathy, and had no real friends. He was prone to bizarre exaggeration - for example even suggesting, we were told, that he had been the driving force behind the Major-Clinton Northern Ireland peace negotiations…In the view of someone who worked closely with him, Savile*

> *"couldn't care less about...people…never felt sorry for anybody.." At least one psychiatrist at Broadmoor told us that she "thought he had a major personality disorder..."*[14]

8.5 We interviewed Peter Davies, a chief police officer and formerly chief executive of the Child Exploitation and Online Protection Centre. He described how power and vulnerability were key features of grooming and abuse of children and how this applied in Savile's case. He told us:

> *"In Savile's case, power was celebrity; access to the corridors of power; the aura of invincibility and untouchability, and also the access to children and vulnerable people that that power was clearly diverted towards...you are investigating people in hospitals and also children and star-struck teenagers meeting one of the biggest stars of their day."*

8.6 Mr Davies went on:

> *"sexual abuse is not solely about personal sexual gratification, but there are many psychological dynamics about power and control and status too."*

8.7 We also interviewed Dr Jackie Craissati MBE, clinical director in forensic and prison services at Oxleas NHS Foundation Trust, a consultant clinical psychologist with particular expertise in sexual offending and personality disorder. She was keen to stress that a wide variety of pathways lead people to become sex abusers and that it is necessary to keep an open mind about what causes an individual to commit sexual offences.

8.8 Dr Craissati had no personal contact with Savile but she had seen the documentary film made by Louis Theroux about Savile in 2000 entitled *When Louis Theroux met Jimmy Savile*. This had suggested to her the possibility that Savile was too close to his mother and that his mother, while loving, had also perhaps stifled him. We asked Dr Craissati to offer an explanation, albeit a speculative one, for Savile's behaviour. She suggested that, as a result of his relationship with his mother, in Savile's mind most women were "*sexual and persecutory*" and could be used and attacked and were to be kept entirely separate and seen differently from his "*sacrosanct, perfect*" mother. Dr Craissati said:

[14] Broadmoor investigation report, para. 6.27

> *"with mothers who say* [women] *are not good enough for you, you're special, one of the issues perhaps I think…is this issue of someone who has grown up with a sort of arrogance and specialness which means that they are entitled."*

8.9 She went on:

> *"…there is a personality disorder coming in to play here, narcissism, essentially. You have a narcissistic man going out raising millions feeding into his ego, interacting with an interest in girls, which is a very potent combination."*

8.10 Dr Craissati said Savile and the circumstances of his offending were unusual: Savile was not only highly pathological in his personality and sexual deviance but he also had extraordinary access, which gave him the opportunity to commit abuses on an unusual scale. Dr Craissati warned of the risks involved in designing preventive measures based on the experience of Savile:

> *"…creating policies and procedures out of the aftermath of one extraordinarily unusual man is…a nightmare for those of us who are trying to deal with the everyday normal case…it is very rare for a man to look like a paedophile, behave like a paedophile superficially and them actually be a paedophile…and to be a celebrity at the same time…it is an extraordinarily unusual situation."*

8.11 Although Dr Craissati accepted the need for procedural and physical measures to protect potential victims from abuse, she cautioned that *"if you have too much of an emphasis on physical security your, what we call relational security disappears. That is that people become overly reliant on very concrete measures."*

8.12 Like Dr Craissati, Donald Findlater, director of research and development at the Lucy Faithfull Foundation, a charity that works to prevent child sex abuse, stressed that Savile's offending behaviour was unusual. He pointed to the wide variety of people Savile abused. He also said:

> *"I guess he is atypical in terms of sexual offenders; that doesn't mean there are not others with a similar disposition but he is at one end of a spectrum in terms of how he did it and what he did. Many sex offenders are looking for some kind of*

sustained sexual behaviour with one or a few victims they are not looking for a single sexual event of abuse and then move on to the next one. Therefore that means that the process of grooming was very different, the assumptions about not being 'told on', about not being noticed, in a way the arrogance about "I will get away with this" *and the assumption that would be the case."*

8.13 The attendees at our discussion event, which included Dr Craissati and Donald Findlater, had differing views about the prevalence in society of people who might in fact commit sexual abuse. They also differed on the extent to which psychological factors rather than situational factors (particularly opportunity) determined or contributed to Savile's offending and to the offending of others. Nevertheless, they agreed that organisations do need to take sensible measures to protect people from abuse, in particular, they need to reduce the opportunities for those wanting to abuse. One of the attendees, Professor Richard Wortley, the director of the Jill Dando Institute told us:

"I actually don't think much can be learned by looking at the motivations and dispositions of Jimmy Savile. If you want my opinion the reason he did it was because he could, and we could debate whether he was a paedophile, whether he was a hebephile[15] *or we could debate whether he was after power or whatever it is. At the end of the day, he did it because he could get away with it…I think there is a real danger if we start thinking about Savile as a special case and how he can be explained by his unique motivations and dispositions and we think we can identify people like him we will solve the problem; I just think that is misguided."*

8.14 He went on:

"We can try to control the pathology by, maybe, screening people and screening is useful…but it is not going to be completely successful, not by a long chalk. The thing that we do have power over is how institutions are run and the protocols they have and the way that volunteers are managed and so forth".

[15] A person attracted to pubescent children.

"...if you don't know who the Jimmy Saviles are and who they are not, then you better make sure that the roles they are undertaking have adequate supervision to stop both sexual abuse, but also physical abuse and all the other range of abuses."

8.15 Dr Craissati warned of the need to ensure that preventive measures were aimed at tackling all types of abuse and are not focused on sexual abuse or any one type of sexual abuse. She explained:

"I think...it would be a mistake to focus just on sexual abuse, because I think [with] a lot of emotional abuse or inappropriate behaviour you don't know what pathway it is going down...When people think they are looking for paedophiles they are going to miss more than they catch".

8.16 Most people we spoke to, including practitioners in the NHS, experts in the field of sexual abuse and safeguarding and the historians referred to in the previous section, suggested that society was much more aware of the issues relating to sexual abuse than had been the case in previous times. The matter is more frequently discussed in the media than in Savile's day. Operation Yewtree had enormous publicity and resulted in large numbers of people coming forward to make allegations of historical sexual abuse. Our visits to NHS hospitals and the responses to our call for evidence indicated that NHS organisations were alive to the risks of abuses on their premises. Furthermore, as the individual hospital investigation reports make clear, NHS hospitals now have more robust local management and governance arrangements, making it less likely that an individual could exercise the same influence as Savile or gain the access and opportunities he had to commit abuses. Nevertheless, when we discussed with Peter Davis the likelihood of a repetition of events along the lines of the Savile case, he said:

"It is still true to say that between 60 and 90 per cent of all sexual abuse of children goes undisclosed to anybody according to NSPCC figures, and there are many examples. For example there are some localised grooming cases - Rochdale, Rotherham and Oxford and so on - where victims don't even realise they are victims until they are quite a long way into a cycle of being victimised. Many victims don't have the confidence or know how to disclose to anybody. Against that current background I find it very hard not to believe that we can just say that times are different now and it could not happen again. I think it still could, although it is less likely now we have heard of Savile. In my view there is

absolutely no sense in which we can say "well that couldn't happen now" *because all the different elements are still happening."*

8.17 Detective Superintendent Paul Sanford, deputy lead on child abuse at the Association of Chief Police Officers (ACPO), supported Peter Davies's view of the present risks of child abuse. He told us:

"…from this work we are doing in our office at the moment, some of this isn't unique to the health setting, it is carried across institutions and it is not all historic. It is happening now and there is a real danger in some of the commentary that has gone on recently that takes us back to saying this is something that happened in the '70s and '80s, and that breeds complacency. It is very dangerous…"

8.18 Similarly, Peter Saunders, chief executive of the National Association for People Abused in Childhood (NAPAC), told us:

"Not all abusers like Savile are dead and buried. There are very many out there still and we need to tackle that problem…abuse is a very real and present scourge in our society."

8.19 Our discussions made us aware of the unusual nature of Savile's offending behaviour. Our discussions and the investigation reports also highlighted the unusual and historical set of circumstances that allowed Savile to use his celebrity and fundraising to gain influence and access in NHS organisations and gave him opportunities to commit abuses on their premises. But we believe there is still a likelihood of other individuals, including those in charitable or volunteer roles, seeking to take advantage of the opportunities NHS hospitals present for committing abuses against children and other vulnerable people, or of using their engagement with NHS hospitals for the purpose of self-promotion or for gaining inappropriate influence. We accepted the warnings we were given about measures aimed only at preventing a repetition of the Savile case rather than measures aimed at tackling abuse in the widest sense. We also took account of the dangers of organisations relying too heavily on physical and procedural security measures, rather than developing the right cultures and behaviours to mitigate the risks of abuse.

9. Findings, comment and recommendations on identified issues

9.1 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- security and access arrangements, including celebrity and VIP access;
- the role and management of volunteers;
- safeguarding;
- raising complaints and concerns (by staff and patients);
- fundraising and charity governance; and
- the observance of due process and good governance.

9.2 In order to assess how the NHS deals with these matters today and the adequacy of present guidance and procedures in relation to them, we relied not only on the reports of the various NHS investigations but also on evidence we gathered ourselves, including our visits to hospitals across the country, and from the responses to our call for evidence.

9.3 In this report we deal in turn with each of the themes and issues we refer to above.

9.4 Our recommendations for NHS hospital trusts are also addressed to Monitor and the NHS Trust Development Authority under their duties to regulate NHS hospital trusts. Most of the recommendations are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of childen and adults.

9.5 Non-NHS hospital and care organisations should consider this report and implement any of our recommendations relevant to their services.

10. Security and access arrangements

Improvements in security arrangements

10.1 The Leeds investigation concluded that security at Leeds General Infirmary during the early part of Savile's association with that organisation was *"rudimentary"*. It heard accounts of keys to secure areas being kept in unlocked cupboards and concluded that Savile probably had access to them. The investigation at Stoke Mandeville found that the hospital "*operated on an open access policy throughout the 1970s and 1980s.*" Wards were unlocked and the organisation "*did not have security or controlled access as part of either its culture or working practice. The environment was large, open and difficult to observe*"[16]. From the time that Savile first started working as a volunteer porter at the hospital he had *"free and unsupervised access to most clinical and non-clinical areas within the hospital."*[17]

10.2 Similarly, the Broadmoor investigation report describes security arrangements at Broadmoor Hospital at the time that Savile first volunteered as "*primitive*". Their report concludes that *"for a considerable part of Savile's period of association with [Broadmoor], and certainly up to the 1990s, it was possible for him to access ward areas without 'checking in' either with ward staff or at the separate entrance area to the female wing"*.[18] It also says that Savile's "*unrestricted access to secure and clinical areas of the hospital remained unchallenged for many years*".[19]

10.3 One security manager told us about her experience of the management of security when she started working at a London hospital in 1991: "*There were no controls, no policies and procedures, so it has moved on dramatically*". And members of the security team at another hospital told us that their hospital's contract with its security provider 15 years earlier had mainly been concerned with protection of property, equipment and cash whereas now it focused more on the safety of patients and staff.

10.4 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with

[16] Stoke Mandeville investigation report, paras. 11.78 and 11.82
[17] *Ibid*, para. 11.87
[18] Broadmoor investigation report, para. 6.13
[19] *Ibid*, para. 6.17

what we learnt about how awareness of security and security arrangements elsewhere in the NHS has been developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.[20]

10.5 Staff at all the hospitals we visited wore identification badges. So long as badge holding is properly authorised and monitored, badges provide staff, patients and visitors with a quick and easy means of checking and being reassured that someone has the right to be on hospital premises.

10.6 Many hospitals told us they now have locked wards, with staff able to gain access with swipe cards or electronic proximity readers. Cards and readers are programmed to give staff access only to wards and departments they need to access. These security systems have the advantage that areas can be 'locked down' if necessary. Other hospitals have locked wards with access by entering numbers on a keypad.

10.7 Some hospitals do not have the level of physical security we refer to. One hospital we visited introduced measures to control access within the hospital only in the last three or four years and at the time of our visit in 2013 it applied only to certain wards such as maternity and to the wards in a new building.

The limitations of physical security measures

10.8 No doubt it is sensible for hospitals to try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us, however, that a total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their 'facility' and they have many and varied reasons for wanting access to it. It is desirable that hospitals are accountable and open to the scrutiny of the communities they serve. Peter Allanson, trust secretary and head of corporate affairs at Guy's and St. Thomas' NHS Foundation Trust said his hospital:

[20] Department of Health and NHS Counter Fraud Service (December 2003) *A Professional Approach to Managing Security in the NHS*.

> *"is a public building, you want it to be reasonably welcoming, and part of the community...it fails if it isn't and you have a corporate social responsibility to this community to its citizens...and being part of the South Bank."*

10.9 Even restricting access at ward level via the sort of entry systems we refer to can be problematic because closed wards require staff to open doors or to operate a buzzer entry for visitors and others without passes. At busy times this can be time-consuming and disruptive. Security staff at one hospital we visited acknowledged that while all their wards should be locked, at certain times the doors were kept open on some wards to make access freer for visitors.

10.10 Even where doors are locked, unauthorised people may still gain access by 'tailgating' - slipping through a door when it is opened by or for others. Staff at one hospital gave us a recent example of two people entering a ward by tailgating. They were challenged by staff and ultimately detained by the police.

10.11 In any event, as we observe above, hospitals need to be accessible to some degree, and their security systems will always rely on individual staff to ensure those systems operate properly. As one associate director of nursing put it:

> *"I think in a hospital security is always a challenge as there are so many entrances and back doors. The wards and clinical departments are locked but it is making sure that people lock them down at night. If people do walk on to wards, I would expect them to be challenged by staff saying "can I help you".*

10.12 In addition to physical security measures and sensible restrictions on access, hospitals should put in place proper staff training aimed at highlighting the vulnerability of security systems, and the need for all staff to see it as their business to challenge those not wearing security badges or about whom they have concerns or suspicions. We were reassured to hear from a number of interviewees that these matters were a feature of their hospital's training programmes.

Celebrity and VIP access arrangements

10.13 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years, and was *"able to move freely around the Infirmary at all hours of the day or night..."*[21] He had access to areas of the hospital and its services "*that would be highly unusual for any porter, especially a voluntary one.*"[22]

10.14 The Leeds investigation team found that Savile "*would often make unannounced visits to wards and departments. His visits included the accident and emergency resuscitation room, visiting wards to accompany clinical staff in wards rounds, and we had one report of him assisting a nurse in giving a child who was an in-patient, in intensive care, a bed-bath.*" They came to the view that *"this level of access was available to Savile on account of his celebrity status rather than his role as a volunteer porter"*[23]. They concluded that "*...no senior manager appeared to have responsibility for 'minding' Savile in the Infirmary, as would be commonplace with visiting celebrities today. Savile's day-to-day presence at the Infirmary had become 'invisible' to those in charge. In addition, to many staff on wards and departments, he was regarded as 'part of the furniture'".*[24]

10.15 The Leeds investigation team also found that at the time they began their investigations the Leeds Teaching Hospitals NHS Trust had no "*policies or procedures governing access to hospital premises by celebrities and media crews, i.e. those who could be seen as 'sanctioned visitors'.*"[25]

10.16 The Stoke Mandeville investigation report shows that the circumstances of Savile's access within that hospital were similar to those at Leeds General Infirmary. The Stoke Mandeville investigation team found:

> *"The lack of management and monitoring of Savile is key to the issue of his access, permissions and privileges. He was accepted into the Hospital and set down in the middle of a busy and sprawling organisation with a myriad of cultures, customs and practices. In this kind of environment Savile was able to go*

[21] Leeds investigation report, page. 84
[22] *Ibid*, page. 86
[23] *Ibid*, page. 86
[24] *Ibid*, page. 106
[25] *Ibid*, page. 181

about his business, not only unchallenged, but also with the perception of sanction from the senior hierarchy".[26]

10.17 The investigation team concluded that senior managers were remiss because:

"A celebrity volunteer was allowed unmanaged, unmonitored and unsupervised access to an NHS site and the patients, staff and visitors within it over a period of many years, with no monitoring or management in place."[27]

10.18 The Stoke Mandeville investigation team found too that:

"Buckinghamshire Healthcare NHS Trust had no procedure in place specifically to manage VIP or celebrity visitors. It is currently updating its volunteer and visitor policy to include procedures for all celebrities and VIPs, including politicians, who may visit the organisation. It will become a tenet of basic Trust policy that every VIP or celebrity, regardless of their status, will be treated in the same rigorous manner as all other visitors to the Trust".[28]

10.19 We took evidence from staff at two hospitals in London that regularly receive visits from high profile celebrities or politicians. Both had clear, well-tested policies for deciding whether or not such high-profile visits ought to take place and the arrangements to manage them. The policies included a requirement that such visitors be accompanied at all times by staff of appropriate seniority and that consideration be given to other safeguarding implications of such visits. We were reassured to learn that the requirement that VIPs be accompanied at all times (which serves to protect both the visitor in question as well as the hospital and its patients) was strictly enforced.

10.20 Reports of the Savile investigations undertaken at other hospitals show, however, that at the time of the investigations, most of the organisations in question did not have formal written policies for planning and managing visits by celebrities and VIPs or for supervising celebrities and VIPs on hospital premises. This is mirrored by what hospital trusts told us in response to our call for evidence and in what we found at the other hospitals we visited.

[26] Stoke Mandeville investigation report, para. 11.110
[27] *Ibid*, para. 11.113
[28] *Ibid*, para. 14.12

10.21 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare.[29] Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

10.22 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures. Staff at one of the two London hospitals we refer to above gave us good examples of when they had been able to rely on formal policy to insist that VIP visitors were escorted at all times.

10.23 While most hospitals may not have many or indeed any visits from high-profile visitors almost all hospitals receive visits from 'lesser', more local celebrities and VIPs, for example local politicians and local news film crews. We were concerned to find at two hospitals we visited that local film crews were not appropriately escorted.

10.24 We recommend that all NHS hospital organisations develop a policy for managing visits by celebrities, VIPs and other official visitors. It should be made clear in the policy that it applies to all visits by such visitors whoever they may be.

Recommendation

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

[29] Amanda Witherall, the chief executive of the Association of NHS Charities (which represents the 92 NHS charities that raise approximately 90-95% of all NHS charitable funding) estimated for us that less than 10 of their member charities work with celebrities.

11. Role and management of volunteers

11.1 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising. Acting as a volunteer, he oversaw the £10m appeal to rebuild the National Spinal Injuries Centre at Stoke Mandeville and he took part in fundraising activities at many other hospitals around the country.

11.2 Reports on the investigations at Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals make clear that Savile went on to use his volunteering, fundraising and celebrity status to widen his roles and influence in those hospitals and to obtain a degree of access beyond any that should have been accorded to a volunteer. We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

The extent and purpose of volunteering in the NHS today

11.3 Research in 2013 by the charity The King's Fund on behalf of the Department of Health into the scale and impact of volunteering in acute trusts in England indicates significant variations between trusts in their volunteer numbers but on average acute trusts in England had 471 volunteers who offered their time at least once a month. This equates to more than 78,000 volunteers across 166 acute trusts, contributing more than 13 million hours per year to the acute sector.[30] These figures did not include the contribution to acute trusts by volunteers undertaking governance roles. Trusts' average spend on managing and training volunteers was £58,000 and based on the hours that their volunteers contributed, the researchers estimated that their activities represented an 11-fold return on the money acute trusts invested in their volunteer programmes.

[30] Galea. A, and others (November 2013) *Volunteering in acute trusts in England; Understanding the scale and impact*. London: The King's Fund p.12

11.4 The research also showed that most acute trusts envisaged a significant expansion in the number of volunteers within the next three years, in many cases by more than 25 per cent.[31]

11.5 All the hospitals we visited had large volunteer programmes. One district general hospital had 250 registered volunteers who gave 1,400 hours service per month, another had 350 who gave 4,000 hours per month. A large teaching hospital told us they had 600 active volunteers who gave 75,000 hours service per year. The largest volunteer programme we found was at King's College Hospital NHS Foundation Trust in London (King's). The head of volunteering told us they had 1,500 volunteers who gave a total of 5,500 hours per week to their four hospital sites. Nearly all the hospitals we spoke to said they would like more volunteers.

11.6 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded.

11.7 The traditional stereotype of the older, white, female volunteer is no longer accurate. The voluntary services managers we spoke to told us that the average age of volunteers in their hospitals had dropped significantly as more people, especially young people, saw volunteering as an opportunity to gain employment skills and enhance their CV. Volunteering in a clinical setting has become a necessary qualification for entry to some clinical education courses, while many unemployed people see volunteering as a step on the ladder back into employment. More men and more people from black and ethnic minority backgrounds are volunteering. At Birmingham University NHS Foundation Trust 35 per cent of 600 volunteers were men, 50 per cent were under 50 and 38 per cent came from black and ethnic minority backgrounds. Carol Rawlings, associate director of patient affairs at the hospital told us:

> *"As an organisation we have made an effort to reach out to other communities. What we wanted to do really was reflect the community of the patients within our hospital..."*

[31] This is in keeping with the Department of Health's strategic vision for volunteering *Social Action for Health and Well-being; Building Co-operative commmunities* (2011).

11.8 The profile of those who volunteer as part of the programme at King's is perhaps untypical and no doubt owes a lot to the size of the programme and the fact that King's is a major teaching hospital in South London. However Katherine Joel, the head of volunteering at the hospital, said:

> *"We are a very young and a very diverse service. The vast majority are students between 16 and 21. 70 per cent of our volunteers are under 30, though we do have some volunteers who are retired. And 68 per cent are from BME background, which is over representative of Camberwell."*

11.9 She also told us that 20 per cent of their volunteers were men.

11.10 This increasing diversity of hospital volunteers is in keeping with the findings of the King's Fund research mentioned above. Sixty-six per cent of the respondents to the survey used in that research said volunteers tended to be younger people and 56 per cent said they were more ethnically diverse.[32]

11.11 Many, perhaps most, volunteers still undertake traditional roles such as meeting, greeting, guiding and signposting patients and visitors, serving in hospital shops, operating tea and library trolleys, pushing wheelchair patients, helping to organise entertainments but the hospitals we visited described how the roles of volunteers had widened in recent years. Volunteers were increasingly undertaking roles that involved closer interaction with patients, and perhaps more directly enhanced the patient's hospital experience and more closely supported their care. We heard of volunteers helping patients to eat, helping with exercise therapies, cuddling babies, playing with children, reading to coma patients, befriending patients and offering information and peer support. Fiona Skerrow, voluntary services manager at Hull and East Yorkshire NHS Trust, told us that the services of volunteers at her hospital could now be encapsulated by the slogan *"Volunteers don't just make tea, they make a difference"*. She said *"That's what we have used throughout my time here, because they do make a difference"*. Carol Rawlings, chair of the National Association of Voluntary Services Managers (NAVSM) - the membership body for voluntary services managers in the NHS - and associate director of patient affairs at University Hospitals Birmingham NHS Foundation Trust told us that without volunteers in the NHS *"there would be a huge gap...of course our professional staff are there to undertake*

[32] Galea. A, and others (November 2013) *Volunteering in acute trusts in England; Understanding the scale and impact*. London: The King's Fund p.5

specific roles but the volunteers are able to do some of those things that add value to [those] role[s] that healthcare professionals may not necessarily have time to…do."

11.12 The justification for and potential benefits of voluntary service schemes in NHS hospitals was perhaps best summed up by the managers of the volunteer programme at King's. They explained that the ethos of their present programme arose from work in 2009 to develop the trust's organisational values. These focused above all on improving the experience of patients. Volunteers were seen as able to make an important contribution to that aim. Jane Walters, the director of corporate affairs told us:

> *"We knew that there were all sorts of things that our patients said they wanted, but our staff are so hard-pressed they didn't have time to provide, and it was the added value...It's not about volunteers doing things that paid staff should be doing".*

11.13 The volunteer programme also helps to make a difference in the hospital's local community, as Jane Walters explained:

> *"…the ethos is very much to try and bring the community and the hospital closer together, to provide opportunities for people in the area to get engaged with their local hospital, but essentially, to be a bit of a deal…we value the time that you are prepared to give to help our patients, and in return we will give you opportunities...for interesting roles. We will give you access to training and support, and, hopefully, a pathway through to further education or employment if that's what people want to do."*

11.14 At King's and elsewhere a number of staff had been offered employment having started working as a volunteer.

11.15 Jane Walters also referred to the role that volunteers at King's played in ensuring that the hospital was open and transparent in the way it operated and more accountable to and engaged with its community, in keeping with its status as a foundation trust. King's has volunteers on all except one ward, including on the intensive care ward. Ms Walters said:

"We all know about the Francis report, and we all know how important it is to have eyes and ears constantly around in the hospital. I think we saw [volunteers] as another opportunity to make sure that we had openness and transparency of all our clinical areas."

11.16 The values and principles underpinning the volunteer scheme at King's were echoed in what we were told by staff at the National Council for Voluntary Organisations (NCVO), the national organisation that champions and supports volunteering and civil society. Kristen Stephenson, the volunteer management and good practice manager at NCVO said:

"…one of the core principles of volunteering is that there is a mutual benefit there and, obviously, that is at the centre of the nature of volunteering, so that…of course there is benefit to adding value to the services and what the NHS does…whether that is improving patient experience or whether it is better social interaction for patients or whether it is about bringing people from the community into the hospital, [but] it is [also] going to be that it helps develop skills in the community, it provides opportunities for people to learn, it opens up the institution. I think there is an element of looking at the broader picture of what benefit volunteers bring to the organisation and also what benefit volunteering can have for people…there has been research that has…demonstrated that volunteering can benefit health and well-being".

11.17 Prior to the research on the scale and extent of volunteering in acute hospitals referred to above the Department of Health had commissioned the King's Fund to research and report on volunteering across the health and social care sector. That report concurs with the view that volunteers contribute to improving patient experience in hospitals and build closer relationships between services and communities. It also identifies the benefits brought to the sector from the part volunteers play in tackling health inequalities and promoting health in hard to reach groups, and in supporting integrated care for people with multiple needs.[33]

[33] Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future.* London: The King's Fund. p.1

The management of volunteers

11.18 Given the scale of the volunteer presence and the extent and nature of the work they do in NHS hospitals, as well as the potential for further benefit to the NHS from volunteer schemes, arrangements for managing volunteers, including the risks associated with their presence in hospitals, must be robust and command public confidence.

11.19 Staff at NCVO made clear that effective management of volunteers requires strategic, board level commitment and leadership. Kristen Stephenson told us:

> *"a message that we consistently push is that if volunteers are going to be involved more within public services, and especially within the NHS, then there needs to be that strategic, top-level commitment...to [ensure] good volunteer management and to make sure that it is resourced...that top-level strategic commitment ...should be owned by the board like any other strategy in the organisation is. They should be as responsible for delivering on the volunteering strategy as any other element that they might performance manage."*

11.20 Ms Stephenson pointed out that beneath the strategy organisations need to have a clear volunteering policy.

11.21 Researchers at the King's Fund describe the need for organisations to take a strategic planning approach to volunteering as follows:

> *"The importance of a strategic approach to volunteering is that it encourages providers to articulate how working with volunteers will help the organisation to meet its core objectives, and thereby helps to give volunteering a prominent and useful role within the organisation."*[34]

[34] Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future*. London: The King's Fund. p.17

11.22 All those we spoke to about volunteering in NHS hospitals, as well as the researchers at the King's Fund, acknowledged that the proper management of a volunteer scheme demanded resources and had a cost. The King's Fund researchers said:

> *"To get the most out of volunteering, organisations need to invest in managing volunteers and ensuring they are supported and well motivated"*[35]

11.23 Is Szoneberg, director of volunteering operations at CSV, told us:

> *"I think that there is still the view that volunteering is free. However, if you are going to do it properly it costs money because you need proper processes, good practice, proceedures, oversight and all the other things that...you need if you are employing staff…you still need a lot of those bits of structure around it in order for it to function properly, and in order for [volunteering] to be effective and meaningful for the volunteer and for those who are receiving help."*

11.24 And Kristen Stephenson of NCVO told us:

> *"Not only do you have the staff costs and the management costs, you have your volunteer training costs, potentially you the have costs for expenses of volunteers, you might then have costs around communications with your volunteers, newsletters, emails, whatever that might be, admin costs, CRB checks."*

11.25 Ms Stephenson and her colleagues at NCVO said the extent of the resources required to operate a successful volunteer scheme depends on the scale of the volunteer programme in question and the types of roles that volunteers are undertaking. Nevertheless, they and others we spoke to agreed that appropriate management of volunteers in NHS hospitals and the management of the risks associated with their work requires robust recruitment and selection, appropriate training, supervision and management of volunteers.

11.26 It was clear from our investigations that the management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them and in their robustness. Some of the hospitals we visited, including two smaller

[35] Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future*. London: The King's Fund. p.18

district general hospitals, demonstrated that their volunteer schemes were sponsored and overseen at board level, were subject to strategic planning processes and that their voluntary services managers had appropriate management and administrative support. The volunteer scheme at King's is of strategic importance to the organisation, is overseen at board level and has significant resources committed to it. Their head of voluntary services is supported at their Denmark Hill site by a team of two recruitment managers, two recruitment coordinators and a part-time administrator and at another site by a full-time manager and a part-time administrator.

11.27 At the other end of the scale, we encountered voluntary service managers working in relative isolation with little or no connection to the wider management system of the hospital and with little support. We heard of some voluntary services mangers who undertook that role as part of a wider portfolio. One voluntary services manager with a large number of volunteers told us that she had become part of the hospital's facilities directorate as a result of recent management changes and had no engagement with board-level directors. Furthermore, she shared cramped offices with two others and the only assistance she had was six hours a week from a volunteer administrator. This meant that she spent most of her time on the administration necessary for the recruitment, checking, training and arranging placements for volunteers; she had little if any time to go into the hospital to oversee and manage the wider operation and development of the volunteer scheme. Her total budget for managing 250 volunteers was about £9,000 a year. She said: *"To have a voluntary services manager in place you really do need to support them, and there are a lot of us who aren't."*

11.28 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS). Most of the hospitals that responded to the call for evidence told us that in line with the relevant legislation they undertook checks only against the DBS's lists of people barred from working with adults or children (the barred lists) if the volunteer was engaged in 'regulated activity'. They also said that they undertook DBS checks only at the time of recruitment but not thereafter.

11.29 Some hospitals told us they had encountered resistance from some groups of long-standing volunteers to undergoing DBS checks. The Savile case clearly shows that being a volunteer over many years is no guarantee of a person's suitability to undertake such a

role. Moreover, as Mark Devlin, the former chief executive of Medway NHS Foundation Trust pointed out to us, hospital staff tend to place a greater degree of trust in long-term volunteers, which may heighten the need to ensure that such volunteers are subject to periodic checks. Mr Devlin said:

> *" ..as a volunteer in any capacity, whether it's with a tea trolley or in a shop, you are in a trusted capacity.....you become a familiar face in the organisation and then people will probably...keep a door open for you because it is always "Oh, its that lady from the shop. She's fine" So it's the familiarity thing isn't it. That people trust familiarity and familiar faces"*.

11.30 We set out in greater detail in section 12 below why we believe that the definition of 'regulated activity' should be expanded so that all NHS hospital staff and volunteers (including volunteers provided by third party organisations) who come into contact with patients and their visitors are subject to enhanced DBS checks including checks against the barring lists, and that such checks should be undertaken on a periodic basis. We say here only that we believe that hospitals that do not undertake such checks on their volunteers are placing patients, visitors and their workforce at unnecessary risk.

11.31 Hospitals told us that they gave new volunteers induction training. This involved participating in general hospital induction sessions and in local induction on the ward or in the department to which the volunteer had been assigned. However, at one hospital we visited induction training amounted to no more than a one-to-one session with the voluntary services manager and volunteers did not take part in the hospital's general induction for staff or receive training in safeguarding. Volunteers should be given induction training that imparts the values of the organisation as a whole, and the expectations and responsibilities of their role. This should include the role they play in safeguarding patients, visitors and colleagues.

11.32 Safeguarding featured in the training undertaken at the other hospitals we visited and those that responded to our call for evidence but in some cases it took the form of an online module to be completed by the volunteer in their own time.

11.33 Some of the hospitals we had contact with did not require their volunteers to undergo refresher training. Carol Rawlings, chair of NAVSM, acknowledged that the failure of hospital organisations to retrain their volunteers is a problem. In response NAVSM

produced a document in early 2013 in conjunction with Skills for Health[36] on training for volunteers that sets out the matters on which volunteers should receive training and how often it should be updated[37].

11.34 Many volunteers now undertake roles that bring them into close contact with clinical teams and with patients. Many volunteer roles require volunteers to develop relationships of trust, confidence and friendship with patients and their carers. These relationships may lead to the sharing of information and concerns including some that might indicate abuse and other safeguarding issues. If such information and concerns are to be dealt with properly and not brushed aside, as was the case with concerns raised by some of Savile's victims, volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding issues and to respond to them appropriately, including escalating matters to senior staff.

11.35 At most hospitals we had contact with, supervision of volunteers was the responsibility of the manager of the ward or department where the volunteer had been assigned. A number of interviewees said levels of supervision of volunteers varied significantly depending on the manager in question, and many people pointed out that whatever the arrangements for supervising volunteers they could never be watched over all the time.

11.36 Research undertaken in 2012 sought to identify risk factors in relation to the ways in which sex offenders become part of organisations and to propose good practice to safeguard children against abuse. In their report the researchers refer to a number of organisational factors (as described by the offenders who participated in the research) which may have contributed to an environment in which abuse could occur.[38] Among these were:

- recruitment procedures were not rigorous;
- selection processes such a interviews were not particularly challenging;
- insufficient screening of references;

[36] Skills for Health is the sector Skills Council for health. It helps the UK health sector develop its workforce.
[37] NAVSM (2013) *Guidelines for Volunteer Induction, Statutory and Mandatory training*
[38] Erooga, M. and others (2012) *Towards Safer Organisations II. Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*. London: NSPCC

- failure by the organisation to provide clear indicators of its commitment to child welfare; and
- the organisation not being clear about the importance of rules and regulations.

11.37 In response the researchers make suggestions for ensuring that recruitment and selection processes are rigorous. They also comment on the need for proper induction:

> *"Induction is an important element of the process of an individual joining an organisation. As well as an opportunity to introduce new joiners to the practicalities of their new role it is also an important opportunity to introduce them to the organisation's vision, aspirations and expectations of all staff about working with children and what is acceptable and what is not."*[39]

11.38 The researchers say, however, that the protection of vulnerable people goes beyond matters of recruitment, selection and training of staff:

> *"The single most important message from this research is that the common focus of deterring or preventing "paedophiles" from joining organisations is not sufficient to appropriately safeguard children. As well as providing appropriate "barriers" by way of selection and screening processes it is also necessary to manage organisational processes so that the possibility of inappropriate or abusive behaviour developing or occurring is minimised"*[40]

11.39 They refer to an earlier literature review by the same team that:

> *"…underscored the importance of organisational culture and values on individual behaviour in the workplace, highlighting that in organisations where abuse has taken place there has frequently been a lack of appropriate infrastructure; absence of vigilance in both recruitment and on-going supervision; and a lack of culture and processes where whistle-blowing can take place."*[41]

[39] Erooga, M. and others (2012) *Towards Safer Organisations II. Using the perspectives of convicted sex offenders to inform organisational safeguarding of children.* London: NSPCC. p.12
[40] *Ibid* p.11
[41] *Ibid* p.15

11.40 We believe that the findings and comments of the researchers mentioned above are equally applicable to volunteers in NHS hospitals.

11.41 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering. Given what we found about the variability of proper processes for the management of NHS volunteer schemes, we recommend that all NHS trusts review their arrangements in relation to the management of volunteers, including their training, to ensure they are fit for purpose and offer appropriate risk management.

11.42 Staff at NCVO referred us to the accreditation scheme 'Investing in Volunteers' (IiV), which is overseen by the UK Volunteering Forum and managed by NCVO. It sets a quality standard for all organisations involving volunteers in their work. The accreditation process involves drawing up a development plan and assessment visits. NCVO told us that one hospital found that the framework for managing volunteers devised as part of the hospital's accreditation had resulted in it attracting better volunteers with increased skills who were better able to contribute to the work of the hospital. Hospital trusts may wish to consider as part of their review of their voluntary services whether to apply for accreditation under the IiV scheme.

Recommendation

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

11.43 NAVSM was set up by voluntary services managers in the NHS to provide themselves with peer support, learning and networking opportunities. It has about 140 members, on whose time and goodwill it relies. Our discussions with voluntary services managers and others suggested a need for a properly resourced forum for voluntary services managers, in particular to enable the dissemination of best practice. We recommend that the Department of Health and NHS England should facilitate this.

Recommendation

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support, learning opportunities and disseminate best practice.

12. Safeguarding

12.1 For the purposes of our work we have taken safeguarding to mean actions required to protect people from harm and abuse, particularly sexual abuse.[42]

12.2 The NHS investigations into Savile found that he had had unsupervised access to NHS hospitals and that staff had failed to challenge his behaviour. This gave him opportunities to abuse patients and others. This has led us to consider the robustness of safeguarding measures in NHS hospitals today. This section of our report sets out what we found out about awareness of safeguarding and the present systems and resources in NHS hospitals to respond to safeguarding needs; we then set out our observations on how those systems and resources need to function in order to safeguard people as effectively as possible. We conclude this section by commenting on a number of specific matters of concern in relation to safeguarding which require further consideration and action.

Awareness of safeguarding issues

The development of social attitudes, law and guidance

12.3 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In the 1960s child protection legislation and arrangements were principally focused on local authority responsibilities for children in care and in enabling children convicted of criminal offences to be subject to care orders.

12.4 The 1974 report into the abuse and death of Maria Colwell at the hands of her stepfather gave the issue of child abuse wide public exposure. It led to measures aimed at better coordination of child protection services, including the establishment of area child protection committees, inter-agency child protection conferences on specific cases and child protection registers to identify children at risk.

[42] We acknowledge however that the term can have a wider meaning and implications for professionals engaged in caring for children. See the definition in the introduction to *Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children.* HM Government (March 2013). p.2

12.5 In 1986 the charity ChildLine was set up after a significant public response to a helpline and survey related to a BBC 'That's Life' programme on the subject of child abuse. The following year, what became known as the Cleveland sexual abuse scandal occurred, in which two paediatricians in Middlesbrough diagnosed more than 120 cases of sexual abuse leading to the children in question being removed from their families. Most of the claims of abuse were eventually dismissed and the children returned to their homes, but this case, together with the founding of ChildLine, prompted widespread public and media discussion of issues previously not openly talked about. It led to an acknowledgement of the need for a greater understanding among clinicians and other professionals about child sexual abuse.

12.6 The Children Act 1989, which came into force in 1991, forms the basis of the current child protection system. It introduced the principle that the child's welfare is paramount in any decision that affects them. It sets out in detail what local authorities and courts should do to protect the welfare of children.

12.7 The government published the Green Paper *Every Child Matters* (HM Government, 2003) after Lord Laming's inquiry into the death of Victoria Climbié. Its proposals led to the Children Act 2004. It creates a Children's Commissioner for England. It places a statutory duty on local authorities and their partners (including police, health services providers and the youth justice system) to safeguard and promote the welfare of children and it requires them to cooperate in improving the well-being of children, including protecting them from harm and neglect. It requires local authorities to establish local safeguarding children boards (replacing area child protection committees) to oversee the safeguarding of children and requires local authorities to produce annual child and young persons plans and to appoint directors of children's services.

12.8 In England, statutory guidance to help professionals identify children at risk and promote inter-agency cooperation was introduced in 1991. The current version of that guidance is *Working Together to Safeguard Children* (HM Government, March 2013). It provides guidance on how agencies should work together to safeguard children, sets out roles and responsibilities of individual professionals who come into contact with children and describes child protection processes. It emphasises the shared responsibility of all those in contact with children to protect them from harm. It recognises the risk to children from employees, including volunteers, and the need to develop safeguards to maintain a safe environment.

12.9 In addition to laws and guidance setting out the duties of public bodies to protect children, a number of laws have been introduced in recent years which allow for the monitoring of people who pose a risk to others, creating offences with which they can be charged and stopping them from working with children. Among these is the Sexual Offenders Act 1997, which requires sex offenders to notify police of their names and addresses and any subsequent changes (the sex offenders register). The Sexual Offences Act 2003 updates legislation relating to offences against children. It includes the offences of grooming, abuse of positions of trust, and trafficking and covers sexual offences committed by UK citizens abroad.

12.10 The Bichard inquiry into the Soham murders led to the introduction of the Safeguarding Vulnerable Groups Act 2006, which established a new centralised vetting and barring scheme for people working with children and vulnerable adults. The Act was amended by the Protection of Freedoms Act 2012, which replaced the vetting and barring scheme with a scaled-back disclosure and barring service.

12.11 In 2003 the Department of Health published *Getting the right start: the National Service Framework for Children, Standard for Hospital Services*. This sets standards for the design and delivery of services for children, the safety and protection of children in hospital and the quality of care. It sets an expectation that hospitals will place children who are inpatients on children's or adolescent wards rather than with adult patients.

12.12 England and Wales do not presently have legislation in force aimed specifically at safeguarding adults vulnerable to abuse. However, the guidance *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse (*Home Office and Department of Health, March 2000) sets out a code of practice for protecting adults vulnerable to abuse. It explains how commissioners and providers of health and social care services and other statutory authorities should work together to produce and implement local policies and procedures. In response, local authorities have established local safeguarding adults' boards with procedures similar to those of local safeguarding children boards. And English local authorities will have a statutory duty to establish Safeguarding Adults Boards as from April 2015[43].

[43] Under Care Act 2014 section 43.

Awareness and attitudes within NHS hospitals

12.13 The evidence we gathered indicates that in keeping with the wider societal developments we refer to, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. A number of interviewees referred to the role that the recent scandals of the treatment of patients at Winterbourne View, the findings from the Francis inquiry into Mid Staffordshire NHS Foundation Trust [44] and the Savile case itself had had in heightening awareness of safeguarding. The director of nursing and clinical governance at Royal Brompton and Harefield NHS Foundation Trust wrote in her response to our call for evidence:

> *"The higher profile of safeguarding matters in society and in the media as well as the NHS has led to reports and investigations of more concerns than in the past and I believe that staff in particular are clearer about their responsibilities for this aspect of care of patients, visitors and colleagues".*

12.14 The medical director at Ipswich Hospital NHS Trust told us:

> "*The Savile report* [sic] *and the Francis report have completely changed the culture...There is a much better understanding of people raising concerns, whistle blowing, and people are now much more professionally aware that, if they are practising in an area where they feel the safety or quality of care of patients is being put at risk they are openly coming forward and saying so."*

12.15 The named nurse for safeguarding children at the same hospital told us that the Savile case and the Francis report had "*opened people's eyes, myself included*".

12.16 And the named nurse for safeguarding children at Medway NHS Foundation Trust told us:

> *"When I first started 12 years ago in this role, I know from the nursing point of view that the nurses were very timid and reluctant if they had concerns about what they should do. I feel now looking at the training and auditing work we have*

[44] Robert Francis QC (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.*

done…it has moved in leaps and bounds. I have contact with staff on a day-to-day basis who say "I have these concerns, what should I do?" "

12.17 The awareness of safeguarding among hospital staff and the public at large will no doubt have been greatly increased as a result of the recent report into the shocking child abuse over many years in Rotherham.[45]

12.18 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. We met with many ward staff during our visits. By and large, our conversations with them supported what managers had told us about improvements in training and increased staff awareness in relation to safeguarding.

12.19 Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. For instance, a senior manager at a large inner city hospital trust told us that safeguarding training for security staff amounted to no more than receiving a safeguarding leaflet along with their first pay slip. At our discussion event which considered how hospitals should manage the risks of abuse, Dr Peter Green, consultant forensic physician and child safeguarding lead for NHS Wandsworth and St George's Healthcare NHS Trust told us of his concerns about the effectiveness of safeguarding training. He said organisations need to test whether those who receive safeguarding training in fact learn from it. He said:

> *"Training is completely pointless if you don't assess whether anyone has learnt anything. We have done three surveys in my Trust where we had a gang of students on a particular day and then went and stopped people in the corridor and gave them a questionnaire. We analysed the results. We then learnt from that how…ineffective our training was being. We have changed the structure and modified it. It is no good going to training, ticking the box. What really matters in terms of outcomes is have they learnt something? You must test that. That is a really important message to do with training."*

[45] Professor Alexis Jay OBE (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham (1997-2013)*.

12.20 Furthermore, while most of our interviewees agreed that safeguarding needs constant revisiting and reinforcement, we learnt of hospitals that, contrary to the requirements of the royal colleges and other healthcare professional bodies,[46] did not ensure that all their staff had their safeguarding training updated on a regular basis. The responses to our call for evidence also raised questions about attendance rates at update training sessions at some hospitals.

12.21 Dominique Black, regulatory policy manager at the Care Quality Commission (CQC), who has an operational background as an inspector with CQC warned about awareness of safeguarding matters. She told us her experience suggested that while staff might be aware of the issues raised by the recent exposure of abuses, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

Safeguarding resources

12.22 We asked each of the hospitals we visited to describe their safeguarding arrangements. The largest, best-resourced team we encountered was at Guy's and St Thomas' NHS Foundation Trust in London. This is perhaps unsurprising given the size and nature of the population that the trust serves and that in recent years the trust has taken on the management of community services for the London boroughs of Southwark and Lambeth. However, we were impressed not merely by the size of the team but also by what we learnt about its high profile in the hospital, how it operated and its effectiveness in supporting staff and in handling a large safeguarding caseload.

12.23 The chief nurse and director of patient experience who has responsibility for safeguarding in the trust told us that in 2005 the safeguarding team amounted to one named nurse in child protection, one named midwife and no one with responsibility for vulnerable adults. In August 2014 the team that covered both acute and community care had increased to nine whole-time equivalent staff (wte) responsible for safeguarding vulnerable adults (including those with dementia and learning disabilities) and sixteen wte responsible for child safeguarding. The team worked in an integrated way and covered for each other. All trust staff, including support staff and non-executive directors, undertook

[46] See the royal colleges and professional bodies' Intercollegiate Document (March 2014) *Safeguarding Children and Young People: roles and competencies for health care staff*. London: Royal College of Paediatrics and Child Health.

a one-and-a-half-day induction programme that included safeguarding. Most clinical staff were required to undertake a higher level (level 2) safeguarding training and those caring for children undertook further training (level 3). Refresher training every three years was mandatory. Members of the safeguarding team described how they made links with other parts of the organisation, including the complaints and security teams, and they described how all parts of the organisation made referrals to them and sought their advice. The adult safeguarding lead told us:

> *"When I started we would get referrals from A&E, admission wards and Elderly Care and I would not get referrals from anywhere else. Whereas now I have referrals from every single ward and even outpatient areas, so safeguarding is embedded within the trust."*

12.24 We were impressed by the contribution of the security staff at Guy's and St Thomas' to safeguarding at the trust. At one of the trust's sites security staff were recognised as part of the safeguarding team and attended its team meetings. Security staff contributed as a matter of course to the process of drafting policies relevant to safeguarding. Security staff were managed with a view to making them as approachable as possible and making a contribution to safeguarding beyond merely physical security measures. For example, the trust deliberately employed female as well as male security staff and security staff wore an informal uniform; unlike at most other London hospitals, they did not wear stab vests. Amanda Millard, group director of operations and Jayne King, head of security, explained that these measures were designed to make security management less confrontational and to offer reassurance to the public. Amanda Millard explained:

> *"in terms of conflict resolution, treating violence with violence and teaching staff to be violent can only be bad.."*

12.25 And Jayne King told us:

> *"it's about the message it sends. If we are trying to work with patients and saying we are providing a safer environment and then you have security staff walking around in combat trousers and stab vests, what does that say to you?"*

12.26 Jayne King also told us that as a result of the security staff's profile in the organisation other staff and members of the public had raised concerns with them, including safeguarding issues. She said:

> *"They will call us about things that may be clinical, something they are not happy about and they don't want to take it through their line management route, because they know we have contacts, so we will speak to safeguarding...So we are used as another avenue for people to be able to talk about things..."*

12.27 We believe that Guy's and St Thomas' offers a model for how other groups of hospital staff can contribute to and enhance the work of safeguarding teams.

12.28 One district general hospital we visited was at the other end of the scale from Guy's and St Thomas' for safeguarding resources. When we visited in May 2013, the hospital had a named midwife and a named doctor for child safeguarding, both practising clinicians, but day-to-day management of child safeguarding matters, including staff support and training, rested with the full-time named nurse for safeguarding children. In the months before our visit she had begun to be supported part-time by another nurse. The named nurse for safeguarding children conceded that she found herself stretched by the demands of her role, and there was no cover for her role during her absence. When we visited, the hospital had a nurse lead for adult safeguarding. It had only recently appointed a lead doctor for adult safeguarding.

12.29 This hospital also told us that it had an internal operational safeguarding group that considered and formulated safeguarding policies and practices. Its members were nursing staff, including the director of nursing, the named doctor for safeguarding children, the named midwife, the head of midwifery and a human resources representative. The chief nurse told us they had worked jointly with the trust's HR team on a policy to identify staff with personal problems that might make them unsuitable to work in the hospital.

12.30 Another district general hospital had a number of named doctors and a named midwife for child safeguarding but day-to-day management and coordination of child safeguarding matters rested with the full-time named nurse for child safeguarding. She admitted that she sometimes felt overstretched by her workload. The hospital had only one full-time employee, the safeguarding vulnerable adults' coordinator, with day-to-day

responsibility for adult safeguarding. The chief nurse at the hospital told us: *"One person probably isn't enough adult safeguarding given the complexity of the patients that we now look after".*

12.31 Although this hospital had limited full-time staff resources devoted exclusively to safeguarding the safeguarding staff described how they planned to devolve learning and responsibility across the organisation to ensure greater resilience in their safeguarding work. In particular, they told us they had appointed a clinical nurse lead for adult safeguarding in each directorate, the aim being *"to improve ownership within the Directorates around safeguarding, and to expand the pool of knowledge"*. The safeguarding vulnerable adults coordinator told us she planned to institute regular meetings of the clinical nurse leads and to increase the level of their adult safeguarding training. A similar network of clinical nurse leads for child safeguarding had been in place at the hospital for some years.

12.32 Staff at a children's hospital we visited told us they had two full-time and one part-time member of staff, one of them the named nurse for child protection, with day-to-day responsibility for safeguarding. They too had appointed a member of staff in each ward or department with local responsibility for safeguarding in their service area. This group of staff met together regularly. The chief nurse at the hospital explained the thinking behind their arrangements:

> *"Safeguarding is everybody's responsibility so there's no good having a massive team because potentially people feel they can absolve themselves of their responsibility. So* [the named nurse] *set up link workers from all wards and departments and goes down to A&E and key areas. Working with the A&E staff, and working in different departments to get people to "get it" has been the way that we've tried to work".*

12.33 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. However, we saw that organisations, especially those with limited dedicated safeguarding teams, can increase awareness of safeguarding among staff and their effectiveness in this area by appointing individuals in directorates, wards and specialist teams as safeguarding leads or champions. Moreover, as we learnt at Guy's and St Thomas' and elsewhere, other

staff groups, such as security and HR teams, can make a valuable contribution to the development of safeguarding related policies and other safeguarding arrangements.

12.34 As we show in the next section, the numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding. It is however essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

12.35 We recommend that all NHS hospital trusts review their safeguarding resources, structures and processes (including their training programmes) to ensure that their safeguarding arrangements are as effective as possible.

Effective safeguarding

12.36 A number of recent reports of investigations and studies have considered, some extensively, the organisational, process and behavioural factors associated with failings in patient care and safeguarding[47]. We will not try to restate them all here, nor will we repeat what the separate NHS Savile investigation reports say about the circumstances and failings in each organisation that allowed Savile the opportunity to commit his abuses. Our work gave us the opportunity however, taking account of the findings of all these reports, to reflect on what makes for an effective hospital safeguarding system from the particular perspective of seeking to prevent a recurrence of events similar to the Savile case. In this section we set out what we believe are the most important behavioural and operational features or requirements of such a system. Our intention is to offer guidance to NHS hospital trusts for use in assessing the effectiveness of their own safeguarding arrangements.

[47] See: Robert Francis QC (February 2010) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Lord Laming (2009), *The Protection of Children in England: A Progress Report*. Department of Health (June 2013), *Transforming Care*: a national response to Winterbourne View Hospital. Professor Sir Bruce Keogh KBE (July 2013), *Review into the quality of care and treatment provided by 14 hospitals in England.*

Leadership that promotes the right culture

12.37 We spoke to many people with significant experience of dealing with safeguarding, including sexual abuse. Most emphasised the fact that keeping people safe requires organisations to have values and a culture that engenders awareness of and active responses to safeguarding issues. Jane Held, a former director of social services who now chairs two local safeguarding boards, told us that while effective safeguarding requires adequate resources, it is *"more about culture and behaviours".* She and others were keen to point out that it does not require more bureaucracy.

12.38 The reports of the investigations into Savile's abuses at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor make clear how the social culture of the age, as well as the dispersed and hierarchical management arrangements in hospitals, discouraged the reporting of his abuses and meant that concerns or complaints about him were not properly dealt with.

12.39 The Stoke Mandeville investigation team concludes:

> *"Stoke Mandeville Hospital had complaints policies and procedures in place during the 1970s and 1980s when the ten victim reports were made. However, the management infrastructure was disorganised and weak, which led to a silo-based management of the complaints process. This had the effect of preventing complaints from being resolved appropriately or coming to the attention of the senior administrative tier."*[48]

12.40 The Leeds investigation team comes to similar conclusions:

> *"We have heard repeatedly how the culture of the Infirmary during the 1960s to 1980s was formal, hierarchical and structured in rigid professional lines of accountability. Generally, the staff who witnessed, or who heard disclosures from staff about Savile, were closer to the "front line" of the clinical areas, and remote from the management structure. So if anything was spoken about Savile more widely, it was in the form of gossip, nuance and rumour, and not formally actioned...From what was known about his disruption to clinical areas, and his*

[48] Stoke Mandeville investigation report, para. 13.108

behaviour as a sexual nuisance to female staff, it is hard to accept that this was not seen as potentially harmful, reported to more senior staff, or challenged more rigorously. The culture of the organisation at the time and the attitudes to what was deemed appropriate to report to more senior staff will have had a major influence on behaviours. We heard from both patient and staff victims a strongly held belief that they would not be taken seriously if they reported their encounters with Savile, and that even if they did, and were believed, that no action would be taken because of their perception that senior people in the Infirmary were of the opinion that he did so much good for the organisation and that this should not be compromised."[49]

12.41 The findings of the Savile investigation teams, our own interviewees and research literature[50] make clear that ensuring concerns about sexual abuse are identified and properly managed demands that boards and individual leaders of organisations are clear about and communicate their intention to take safeguarding seriously; it demands mechanisms that allow people to feel able to raise their issues and concerns; and it demands demonstrating that those issues and concerns are dealt with appropriately. It has also been made clear to us that individual members of staff, indeed all individuals, need to be made aware of their obligation to raise matters of concern about abuse and not turn a blind eye. Hilary McCallion, the former director of nursing and education at South London and Maudsley Foundation Trust and formerly that organisation's board lead for safeguarding children, told us how she described to staff the obligations they were under:

"It was about citizenship that was the way I approached it, as a citizen of this country, you have a responsibility, a duty. It's nothing to do with work, this is about your responsibility and duty as a citizen of this country".

12.42 Donald Findlater, director of research and development at the Lucy Faithfull Foundation told us:

"It is about how you create that climate, so everyone knows that "part of my job is safeguarding, this is a place where children or vulnerable adults should expect

[49] Leeds investigation report, p.163
[50] See for example, Erooga and other (2012) *Towards Safer Organisations II: Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*.

to be well treated, and if I notice that they are not being I have an obligation to say something and do something about that".

12.43 We wanted to understand more about the culture of organisations that successfully create a safety conscious environment, so we interviewed the director of people, legal and government and industry affairs at British Airways and the vice-president of Shell UK with responsibility for human resources. They told us that the message of safety was paramount in all their organisational activities - a message constantly reinforced. Shell told us the safety culture was a priority set and demonstrated from the top and thus seen as a priority throughout the organisation. The culture was reinforced by an appraisal system that focused not just on performance but also on how a member of staff had adhered to the behaviours and values of the organisation. In addition, the company routinely investigates "near miss" events where its own employees have not been at fault but which have had safety implications.

12.44 Overall our visits to NHS hospitals suggested that they recognised the need to develop their cultures and values in a way that encouraged the openness, leadership and support that staff needed to deliver effective safeguarding. Some organisations had evidently made progress in developing this culture and values but others still had work to do. In many of the organisations we visited it was made clear to us that at board level safeguarding is not managed as a shared responsibility. One board director told us "*…there is a strong message from our board* [about safeguarding], *to be honest though it is still through me, it is still really only owned by one executive"*. We believe this silo-based approach may undermine the development of an organisation-wide understanding and promotion of safeguarding.

Openness and listening when people, including children, raise concerns

12.45 Many of our interviewees spoke of the need for organisations to train and encourage staff to listen and understand when people raise matters that suggest a risk of harm or abuse and to recognise such risks for themselves. The director of workforce at Guy's and St Thomas' NHS Foundation Trust told us that the Mid Staffordshire and Savile cases were "*an opportunity to remind individuals about how important it is to have open conversations and to listen when people raise concerns."*

12.46 The investigations at Leeds General Infirmary and at Stoke Mandeville and Broadmoor Hospitals revealed that a number of Savile's victims told hospital staff at the time what had happened to them. In most cases, the staff in question brushed off or refused to believe what they had been told or simply failed to respond to it. None of the reports of particular abuses made to staff were dealt with as a matter of serious concern and escalated to senior managers. The same appears to have been the case with Savile's more general, inappropriate and disruptive behaviour. The Leeds investigation team identified the culture required to ensure that matters were reported and dealt with in the following way:

> *"one that welcomes and nurtures staff and patients to feel empowered to raise concerns"*[51]
> *"Those who receive such reports of concerns need to be confident to know what to do with the disclosures, and then act swiftly and responsibly, driven by a guiding principle to safeguard the welfare of patients and staff. Repeatedly, in the accounts from victims - staff and patients - this was not the case."*[52]

12.47 The Savile case illustrates how important it is in identifying abuse that staff do not dismiss what they are told. Interviewees with experience of child sex abuse cases pointed out that staff should especially guard against discounting what children tell them. One experienced children's nurse explained to us "*It would be very rare for a child to make an allegation which isn't true around sexual abuse because they wouldn't know what it was.*"[53] The Stoke Mandeville Investigation report says:

> *"It is an important fact that children often do not have the language to explain the details of a sexual assault; at least three victims who reported what happened to them were non-specific about what Savile actually did."*[54]

12.48 Further, the Savile investigations showed that all hospital staff, including managers, must keep their minds open and be vigilant about the potential for harm and abuse in the hospital. The Leeds investigation report makes the point as follows:

[51] Leeds investigation report, p.164
[52] *Ibid*, p.165
[53] Debbie Parker, deputy chief nurse, Guy's and St. Thomas's NHS Foundation Trust
[54] Stoke Mandeville investigation report, para. 13.89

"We found absolutely no evidence to suggest that those in leadership positions we interviewed knew Savile was sexually assaulting patients and staff. However, we did hear that on occasions they found his behaviour inappropriate for a hospital setting. This discomfort felt amongst some staff at the top of the organisation did not prompt them to appreciate the potential impact Savile may have had on junior members of staff or even on patients for whom they were responsible."[55]

"It appeared that they did not connect their own feelings about him as an individual with any potential wider risk to the Infirmary, its staff or patients."[56]

Approachable and informed senior staff

12.49 Interviewees told us that having senior staff who are visible and approachable is key to getting staff to voice their concerns or suspicions about safeguarding. They must make it possible for junior staff to share their concerns. Senior staff also told us that it is only when they are on wards that they really hear and understand what is happening in their organisations and pick up valuable information about matters that might be amiss.

12.50 The Stoke Mandeville and Leeds investigation reports reveal that the disconnection of senior managers from the 'frontline' of their organisations meant that they did not know about widespread rumours and concerns about Savile's general behaviour or of the individual complaints made by victims of his abuse. Had they been aware of these matters, they could have acted to bring Savile's presence in their hospitals to an end. The Stoke Mandeville report says:

"The Investigation concludes that during the 1970s Savile's reputation as a sex pest and poorly performing porter at Stoke Mandeville Hospital was an open secret amongst junior staff and some middle managers. The Investigation also concludes that complaints were probably filtered out before they reached the attention of senior administrators at the Hospital. Whilst none of the witnesses we interviewed claimed to have had any knowledge of Savile sexually abusing patients or visitors, most of the people that were interviewed acknowledged he was "creepy" *and* "a lecher"*. The evidence shows that the culture, systems and practice within Stoke*

[55] Leeds investigation report, p.173
[56] *Ibid*, p.174

Mandeville Hospital during this period ensured that complaints, concerns and grievances were managed in a 'closed loop' which prevented an open and transparent approach being taken, and that Savile was given a high degree of leeway regarding his performance and conduct due to his celebrity status."[57]

12.51 The Leeds Investigation report says:

"We have heard repeatedly how the culture of the Infirmary during the 1960s to 1980s was formal, hierarchical and structured in rigid professional lines of accountability. Generally the staff who witnessed, or heard disclosures from staff about Savile were closer to the "front line" of the clinical areas, and remote from the management structure. So, if anything was spoken about Savile more widely, it was in the form of gossip, nuance and rumour, and not formally actioned".[58]

"Many warning signs given out by Savile were not seen, and even if they were, it would appear that the systems in the hospital made it almost impossible for concerns to be raised to a level where action could take place or the bigger picture could be seen."[59]

12.52 We heard of good examples of senior managers spending time on wards making themselves visible and approachable by staff and picking up on issues of concern. Northumberland, Tyne and Wear NHS Foundation Trust told us about their 'observational shifts' programme, under which a number of the senior executive team spent a shift working on a ward or in a specialist service each week. One member of that team told us that she discovered the trust's arrangements for medical tests were inappropriate for their rehabilitation patients only as a result of her placement on a rehabilitation ward.

12.53 The chief nurse at Guy's and St Thomas' NHS Foundation Trust also described how for the past nine years she and the rest of the senior nursing team had undertaken clinical work on wards every Friday. She said this had given staff at all levels the confidence to raise concerns with them directly either face to face or in writing.

[57] Stoke Mandeville investigation report, para. 11.117
[58] Leeds investigation report, p.163
[59] *Ibid*, p.164

Training and communication

12.54 Training staff and communicating with them about safeguarding are essential to ensuring that they are properly aware of it and to encouraging them to raise concerns. Good communication between staff is also necessary to ensure that they put together a true and complete picture of any safeguarding problems.

12.55 Organisations told us of the different ways they communicated safeguarding messages to staff. One had put a leaflet in all payslips, assuring staff about how they would be supported if they raised concerns; another used regular staff forums to promote awareness; most organisations told us that safeguarding had often featured in their regular newsletters to staff; and one organisation had a dedicated quarterly safeguarding newsletter. Interviewees spoke of the need for constant reinforcement of the messages about safeguarding. The interim chief executive at Birmingham Children's Hospital NHS Foundation Trust told us "*We continue to do work with our staff and I think this is just a never-ending piece of work around how they raise concerns.*"

12.56 The participants in our discussion event that considered how organisations ought to manage the risks of abuse also stressed to us the need to reinforce safeguarding messages through training and communication with staff. They commended the Scout Association's efforts to ensure safeguarding awareness through the use of a pocket-size card (known as the yellow card). It sets out the association's code of behaviour, based on its child protection policy, the duty to report breaches of the code of behaviour and information about how to report concerns. All adults involved in scouting carry a copy. The participants in the discussion event commended the yellow card for offering a constant reminder and reinforcement of the safeguarding message. Dr Peter Green said:

> "*Some of this stuff needs to be like fire alarm training...safeguarding training should be something you do every week, you repeat it every week so everybody knows it inside out...so we all know exactly what the rules are.*"

12.57 Participants in the discussion event also approved of the way the yellow card makes clear the boundaries of acceptable behaviour and makes clear that inappropriate behaviours will result in disciplinary action. They told us that all organisations need to be explicit with their staff about what behaviours are and are not appropriate and are or are not to be tolerated. They said many safeguarding incidents occurred when there were

'grey areas'. Donald Findlater urged that all NHS organisations and the NHS as a whole ought to consider introducing a code of behaviour along the lines of that produced for the education sector, *Guidance for safer working practice for adults who work with children and young people in education settings.*[60]

12.58 We set out above what NHS hospitals themselves told us about the provision of safeguarding training for staff and volunteers, including the fact that some hospitals do not ensure that all staff and volunteers update their safeguarding training on a regular basis. The report on research undertaken in 2012 into the behaviours and circumstances leading to referrals to the Independent Safeguarding Authority[61] of people suspected of posing a risk of harm to children and vulnerable adults indicates that in the sample of cases examined, staff appeared on the whole to have had appropriate qualifications and training. But the report authors also observe "*what did not emerge...was evidence of the currency or regularity of training. This suggests a potential need for employers to ensure ongoing refresher training where appropriate, as developments occur in the sector or working practices emerge. One example of a potential gap was evident in children's cases in respect of online communication and the use of social media, which was a common feature of grooming behaviour and sexual abuse cases.*"[62]

12.59 Given the importance of ensuring constant vigilance among staff in relation to safeguarding and the potential for new risks of harm to emerge as identified in the ISA research, we believe that all hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at least every three years.

Recommendation

R4 All NHS hospital trusts should ensure that all staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

[60] Department for Children, Schools and Families (March 2009)
[61] The forerunner of the Disclosure and Barring Service
[62] McKenna, K. and Day, L. (March 2012) *Safeguarding in the Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority?* p.54

Responsiveness and feedback to staff

12.60 If hospital staff are to be encouraged to raise concerns about safeguarding, organisations must demonstrate that those concerns will be taken seriously and that the organisation will respond appropriately. The Leeds investigation found that staff who had observed Savile's behaviour and thought it was inappropriate felt inhibited from taking action or reporting their concerns in part because they thought senior managers would not take them seriously or would not act on their concerns. Managers at Birmingham Children's Hospital NHS Foundation Trust told us about a recent safeguarding issue that had been dealt with promptly and decisively and how it had been widely communicated to staff. Staff told us how important this was in promoting and reinforcing the safeguarding agenda. One said: "*It is those kinds of things, when you see that response, you know that they mean what they say and that if you were ever in such a situation, you have that support*".

12.61 And the chief nurse at Guy's and St Thomas' NHS Foundation Trust told us "*If you raise something, you raise a matter of concern and it is not acknowledged and then nobody feeds back then you will not do it again. There is no incentive to do it again…*"

Effective safeguarding: conclusion

12.62 The operational and behavioural features of effective safeguarding we have set out here are hardly novel or revolutionary. They may seem obvious. But the lack of these features in the hospitals with which Savile had a relationship clearly contributed to his acting as he did. NHS hospital trusts need to ask themselves regularly whether their own arrangements are characterised by the specific features of effective safeguarding which we have identified.

Recommendation

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and

- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

Specific safeguarding issues

12.63 In this section we comment on weaknesses we identified in relation to the management of safeguarding in NHS hospitals. We believe these matters require further consideration and action by the relevant bodies referred to in our recommendations.

DBS checking

12.64 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals. Our visits to hospitals and the responses to the call for evidence informed us about the policies and arrangements NHS hospitals have in place to undertake such checks.

12.65 The Safeguarding Vulnerable Groups Act 2006 as amended by the Protection of Freedoms Act 2012 (SGVA) sets out the activities and work that are 'regulated activity' and which a person on the barred lists maintained by the Disclosure and Barring Service (DBS) must not do. An organisation engaging staff and volunteers in 'regulated activity' can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check.

12.66 Subject to a small number of exceptions, it is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is 'regulated activity' as defined by SVGA.[63]

[63] An organisation engaging staff and volunteers not in 'regulated activity' can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible because of their activities. To be eligible for an enhanced check the position must be specified in the Exceptions Order to the Rehabilitation of Offenders Act 1974 and regulations made under the Police Act 1997. The relevant activities encompass and are wider than those defined as "regulated activity" and include, for example, work or volunteering in children's hospitals, the regular care of adults or any form of treatment or therapy.

12.67 The DBS maintains a list of people barred from engaging in 'regulated activity' with children (the children's barred list) and a list of people barred from engaging in 'regulated activity' with adults, (the adults' barred list). A person is placed on a barred list either following a caution or conviction for specified offences, in which case they are barred automatically, or as a result of the DBS exercising its discretion to bar a person after referral and information supplied by employers, providers of 'regulated activity' or professional regulatory bodies.

12.68 We found limitations and anomalies in the present definition of 'regulated activity', and therefore of those subject to barring list checks, which gave us cause for concern.

12.69 Amendments made to SGVA by Part 5 of the Protection of Freedoms Act 2012, which came into force on 10 September 2012, introduced new and more limited definitions of the 'regulated activity' which a person who has been barred must not undertake.[64]

12.70 The new definitions applicable in England and Wales and set out in Schedule 4 to SVGA are perplexingly intricate. Anyone wishing to consider them in full should refer to that schedule and to the Department of Health and Department for Education's guidance notes on regulated activity[65]. For the purposes of this narrative they can be summarised as follows.

12.71 In relation to adults, the new definition of 'regulated activity' is based on six identified categories of activities. A person needs to carry out these activities only once for it to be 'regulated activity'. The categories are:

- healthcare provided by or under the supervision of a healthcare professional;
- providing personal care;

[64] It is an offence for any organisation knowingly to appoint or continue to allow an individual who is barred from working with children or vulnerable adults to engage in a 'regulated activity' with that group. And an individual is committing an offence if they engage in a 'regulated activity' when barred from doing so.
[65] http://www.dh.gov.uk/health/2012/08/new-disclosure-and-barring-services-definition-of-regulated-activity/;
http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/a00209802/disclosure-barring

- assistance with general household matters (including managing cash, paying bills, doing shopping);
- assistance with the conduct of a person's own affairs (e.g. under an enduring power of attorney); and
- conveying someone for the purposes of their receiving healthcare or relevant personal care or relevant social work.

12.72 In relation to children, the new definition, in outline, comprises: a) undertaking on an unsupervised basis the activities of teaching, training, instructing, caring for or supervising children or b) working in a limited range of establishments which includes schools, children's homes but not hospitals. These two categories of activity are 'regulated activity' only if carried out by the same person frequently, defined as once a week or more often, or on four or more days in a 30-day period or overnight. In addition, in relation to children 'regulated activity' includes healthcare provided by or under the supervision of a healthcare professional, relevant personal care and registered child minding and foster care.

12.73 In the context of NHS hospital settings, what amounts to 'regulated activity' in relation to adults differs significantly from that relating to children. With adults, only those staff or volunteers whose work involves direct hands-on or close contact with adult patients can be required to undergo a barring list check, (this applies whether they undertake the activity in question once or more frequently and whether or not they are supervised in it). With respect to children a wider group of staff and volunteers, including those with less intimate contact can be required to undergo a barring list check but only if they undertake such work frequently and unsupervised.

12.74 The arrangements we describe above under which organisations can require barring list checks for staff and volunteers replace the wider arrangements and definition of 'regulated activity' provided for in the Vetting and Barring Scheme (VBS) set up under the Safeguarding Vulnerable Groups Act 2006 after the Bichard Inquiry.

12.75 Under its *Programme for Government* the present coalition government committed to reviewing and scaling back the VBS. The arguments for scaling back record checking and reducing the number of people who could be subject to barring list checks are set out in the report and recommendations of the *Vetting and Barring Scheme Remodelling Review* (February 2011), a review undertaken jointly by the Department for Education, the

Department of Health and the Home Office[66]. Among those arguments is the need to tackle the perception that the VBS *"went too far"*. As the executive summary to the report states: *"the [VBS] would have required 9.3 million people to register with, and be monitored by the scheme and shifted the responsibility for ensuring safe recruitment to move away from the employer towards the state. It would also have had the counter-productive effect of deterring well-meaning adults from working with and improving the lives of children and vulnerable adults."* The executive summary goes on to say that in placing the emphasis on the state, the VBS *"encourages risk aversion rather than responsible behaviour. It is the effective management of risk rather than aversion of risk which is most likely to protect vulnerable people."* In the introduction to the report on page 6 the authors expand on the idea of the VBS encouraging risk-averse behaviour rather than responsible behaviour. They say it gives employers the impression that this central scheme could manage all risk out of the system used for pre-employment checking. The policy lead for disclosure and barring services at the Department of Health made the same point when she told us *"...you can't have a central list of people held by government that are safe to work with adults or children. Just from a common sense point of view, at some point somebody is going to do something that would call into question whether they are safe or not"*. The report and recommendations of the Vetting and Barring Scheme review also highlights the need to balance responsibility to keep children and vulnerable adults safe with the rights and freedoms of individual employees and volunteers.

12.76 However, most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring checks for staff and volunteers working in NHS hospital settings and elsewhere. All but two of the hospital trusts we visited in connection with this report told us that, notwithstanding the legal limitations on their right to require barring list checks, they were in fact continuing to require all staff and volunteers, regardless of the activities they undertook, to undergo barring list checks. The director of nursing at one of the trusts explained his thinking:

> *"I would rather stand up in an employment tribunal and be criticised for not letting somebody [be employed] than be in front of an inquiry panel or coroner or anybody like that. For me there isn't even a balance to be struck…we may have deprived somebody of an opportunity, but the worst case scenario is we could*

[66] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97748/vbs-report.pdf

have deprived somebody of a life, the aspirations they may have in life, because they have been subject to...abuse or exploitation."

12.77 One of the hospitals that responded to our call for evidence told us it required all staff and volunteers to undergo barring list checks before they could work on site:

"In effect the recruitment process is as robust as it is for all staff and this is because we recognise it is not possible for volunteers to be supervised at all times."

12.78 Many staff and volunteers in NHS hospitals who do not fall within the present definitions of 'regulated activity' have legitimate reasons and regular opportunities for being in close proximity to adult and child patients and their visitors. Examples might be those who undertake tea rounds or newspaper selling rounds on wards, clinic or ward clerks, volunteers who befriend or read to adult patients, or those who supervise, entertain or teach children in hospital less than once a week. It is unrealistic to assume that they are all subject to close supervision.

12.79 Age UK, Mencap and the Ann Craft Trust all pointed out to us the inadequate recognition of the particular vulnerability of elderly and learning-disabled patients under the present 'regulated activity' regime. It is our view that the obvious uncertainties and anxieties engendered by illness and hospital treatment make most hospital patients, and the family members who visit them, vulnerable. For many people, the hospital environment alone, can be confusing and unsettling. We believe the vulnerability we refer to may increase the risks of people in hospitals being less able to protect themselves and make them more susceptible to suffering abuse of the type carried out by Savile.

12.80 Furthermore, the research literature on the characteristics and behaviour of people who commit sexual abuse suggests it is committed not only by highly motivated individuals who target organisations with the intention of abusing but also by those of lesser motivation reacting to their situation and environment[67]. In their paper *Situational*

[67] For references to and consideration of that literature see Erooga, M. and others (2012) *Towards Safer Organisations II: Using the perspectives of convicted sex offenders to inform organisational safeguarding of children.*

Theories[68] Stephen Smallbone and Jesse Cale of the School of Criminology and Criminal Justice at Griffith University say, *"In our view, neither dispositional nor situational factors alone are sufficient to explain sexual offending. Rather, sexual offences always occur as a result of proximal interactions between individuals and situational factors."* The paper also refers to the view of sociologists Cohen and Felson that *"For personal crimes (e.g. sexual offences) a suitable 'target' may be someone who is smaller, physically or psychologically vulnerable, unlikely to fight back and perhaps can be intimidated to prevent them reporting the incident".*[69] Or, as Donald Findlater, the director of research and development at the Lucy Faithfull Foundation, put it to us: *"In the hospital situation you also have the problem that people are in beds and are unclothed. They need physical attention in terms of all manner of things, so in a way the situation provides and creates opportunities for those ill-intentioned or for those with shoddy boundaries".* Whether a sexual offender acts as a result of disposition or in response to a situation he finds himself in, or as a combination of the two, it seems to us that patients in hospital settings are more vulnerable and likely to be at greater risk than others from the attentions of sexual abusers.

12.81 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital, and we acknowledge that Jimmy Savile, who was never convicted of sexual offences, may not have featured on the barring lists if they had existed during his time as a hospital volunteer. Nevertheless, we believe that in view of the particular vulnerabilities and risks to those in hospital settings (including the significant increase in the numbers of volunteers in hospitals and the expansion in the roles they undertake) it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients and their visitors to be subject to barring list checks.

12.82 We accept the argument that record checks cannot and should not take the place of 'responsible behaviours'. If we are to keep people safe from being abused then hospitals need to manage the risks of abuse through rigorous employment processes and the proper training, supervision and management of staff and volunteers, as well as appropriate access arrangements and vigilance in relation to visitors. However, we do not

[68]The paper can be found here:
http://c.ymcdn.com/sites/www.ispcan.org/resource/resmgr/events/situational_theories_submitt.pdf

[69] Cohen, L. and Felson, M. (1979) *Social Change and Crime rate trends; a routine activity approach*, American Sociological Review, 44, 588-608.

see how the present system that subjects only some staff and volunteers with access to patients to a barring list check promotes that responsible behaviour any more than a simple blanket requirement for all staff and volunteers to be checked against the barred lists. Indeed, we believe that dealing with the complexities of the current scheme may prove a distraction from the work organisations need to do to develop their own robust and comprehensive risk management systems and culture.

12.83 The Disclosure and Barring Service told us that in the 18 months between January 2013 and June 2014 checks disclosed 157 people working or seeking work in an activity that they were barred from doing. So, although the numbers are relatively small, there is evidence that barring list checks do work to prevent unsuitable people from gaining work in 'regulated activity'. We believe that a blanket requirement for all those working or volunteering in hospital to be checked would be likely to prevent or deter even more of them.

12.84 As Richard Powley, head of safeguarding at Age UK, put it when asked for his view on 'blanket' barring list checks for all those working or volunteering in hospitals: *"We're never going to be able to stop very determined people full stop, but we can make it very difficult for them."*

Recommendation

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

12.85 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. The policy lead for disclosure and barring services at the Department of Health explained to us that a fixed requirement to undertake checks at stated intervals did not protect against those who might commit an offence or become subject of a barring list in the interim and placed too much reliance on central lists rather than local risk management. Good practice, she suggested, was not about employers

"checking every three years, it's about checking when you think there is a risk". However, many of the hospital organisations we spoke to or who responded to our call for evidence told us they required all staff and volunteers, including long-standing staff, to undertake relevant DBS checks every three years.

12.86 We accept that periodic record checking is not foolproof. There is still the risk that hospitals do not pick up on employees and volunteers who commit offences or are placed on the barring lists between such checks. Nevertheless, it is naive to assume that a wholly risk-based approach offers greater assurance in relation to record checking: large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. As a best endeavour at ensuring that hospitals have an acceptable level of practice in relation to record-checking and as a means of maintaining public confidence in the system we recommend that all NHS hospitals should undertake periodic record checks every three years. The implementation of this recommendation should be supported by NHS Employers.

Recommendation

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

12.87 We understand that implementing our recommendations for widening the definition of those subject to enhanced DBS and barring list checks will bear cost implications for NHS trusts. We discussed the matter with representatives of NHS Employers[70] who nevertheless supported our proposal. The former chief executive of NHS Employers told us that his organisation and others employing NHS staff would welcome greater clarity and consistency across organisations in relation to disclosure and barring arrangements.

[70] As its name suggests, NHS Employers is the organisation that advises and speaks on behalf of NHS employers. It devises and supports the implementation of the Employment Check Standards.

NHS engagement with wider safeguarding systems

12.88 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements. In particular, they expressed concerns about the extent to which NHS hospitals fulfilled their obligation, set out in the guidance *Working Together to Safeguard Children* chapter 2, to report to the local authority designated officer (LADO) any allegation that an employee working with children had harmed, or had committed an offence against a child or posed a risk of doing so. One chair of a local safeguarding children board said: *"...we get very few referrals from hospitals…the perception is that LADO is mainly a local authority and schools function".* The same chair told us that 78 referrals to the LADO took place in her local authority area in 2011/2012. Of these only two referred to health professionals, one a GP and the other an ambulance clinician. She told us that there were also 78 referrals in the year 2012/2013 and only three of these were health referrals; none related to people working or volunteering in an acute hospital. The local authority area included a large multi-site teaching hospital serving an inner-city population.

12.89 Participants in our discussion event that considered how NHS hospitals should manage the risks of abuse spoke of the benefits of the LADO system. They referred to the opportunity that LADOs gave those responsible for dealing with safeguarding concerns to talk through a case with someone with significant, recent and local experience in such matters. Donald Findlater of the Lucy Faithfull Foundation also commented:

> *"They...will give you advice or guidance as to whether [a matter] requires a police investigation and...this is who you should be reporting it to, or whether there is a strategy meeting. They just share the responsibility."*

12.90 Steve Reeves, director of child safeguarding at Save the Children, referred to the part LADOs played in "*increasing the ability to curtail offending".* Participants in the discussion event raised concerns about the pressures on LADOs and the need for local authorities to ensure that they were properly resourced to deal with their case loads.

12.91 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations[71] to make referrals to the Disclosure and Barring Service (DBS) in respect of staff or volunteers engaged in regulated activity who posed a risk of harm to children or vulnerable adults. Janet Gauld, director of operations at DBS, told us it was difficult to say how many referrals ought to be made but she said "*considering the size of the workforce in the education sector compared to the workforce in health, there are significantly more referrals coming through in terms of education... our concern is that there are under referrals...*" A report on research undertaken in 2012 into the behaviours and circumstances that led to barring decisions by the Independent Safeguarding Authority (the forerunner of DBS) shows that health care organisations made only a very small proportion of a sample of total cases referred.[72] Nyla Cooper, programme lead (professional standards) at NHS Employers, suggested that many NHS organisations were unclear about when they should make a referral to DBS.

12.92 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Recommendation

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the LADO and to the Disclosure and Barring Service.

Internet and social media access

12.93 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care,

[71] Under section 35 SVGA
[72] McKenna, K. and Day, L. (March 2012) *Safeguarding in the Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority?*

particularly children and young people, from the risks posed by modern information technology.

12.94 The incidents occurred at two hospitals:

Incident 1:
During the course of a consultation with a nurse, a parent let a five-year-old child view pornographic images on the parent's phone. The nurse challenged the parent, who objected to the intervention by the nurse and made a formal complaint.

Incident 2:
The behaviour of a man who had been fundraising on an independent basis for a hospital led to his being banned from the hospital premises. While he was banned he tried to befriend a child patient via social media and had asked the child to invite him into the hospital as her visitor. The child reported him to staff, who advised her to ignore his approaches.

Incident 3:
A teenage patient took photographs of other patients on a children's ward without permission and uploaded them on to a blog.

Incident 4
A doctor showed colleagues pornographic images on his iPhone. He was sacked.

12.95 Staff at the hospital where incidents 1 and 2 occurred told us that the hospital had a policy on computer and internet access use by patients and staff, but the chief nurse told us "*you can write as many [policies] as you like; it's actually policing of these things. It's having the discussion with the young people, it's being clear with them that while you're here we will be checking...we do check...*" She went on "*...society isn't with us. What we're finding is that we're probably laying down rules that their mum and dads aren't.*"

12.96 Another hospital we visited had a policy about internet access and usage but it related only to staff. We discussed this with staff on the children's and young people's wards and they told us that this lack of a policy for internet use by their patients meant they had had to devise policy and rules at ward level. They too told us how implementing

their policy and restricting the use of the internet and social media sometimes put them at odds with patients and their families.

12.97 Nineteen of the twenty organisations that responded to our call for evidence on this point said they had a policy for access to the internet and social media. Thirteen said that their policy applied only to staff.

12.98 The policy lead on information, security and risk management of information services at the Department of Health, (the information policy lead), told us NHS organisations were largely autonomous in their management of IT systems and information governance but they did submit annual self-assessments on these matters and were subject to information governance oversight by the Department of Health, NHS England and the Health and Social Care Information Centre. The department supported local organisations by issuing information governance guidance. However, the Department of Health guidance on information security and governance we saw focused on the security of NHS information systems and the management of information and data by NHS staff. It did not explicitly address misuse of internet access by patients or visitors on NHS premises.[73]

12.99 Patients in some NHS hospitals can use their own devices to access the internet as guests through the portal of the hospital's approved commercial internet service provider or via their own internet service provider. In the first case, the hospital can impose controls or blocks on certain sites or material but it cannot block the use by a patient or visitor of their own machinery or devices or their personal internet server. Even where a hospital imposes controls, they are not foolproof and may not keep pace with rapid developments in internet systems, sites and services. As the information policy lead put it: *"what safeguards there are today may not be relevant tomorrow".*

12.100 The information policy lead agreed with us that the potential for misuse of internet access of the sort illustrated by the incidents we refer to above and the limitations of blocking and controls point to the need for hospital trusts to have consistent trust-wide policy on the acceptable use by patients and visitors of information technology and internet access. Such policy should apply to all internet use within a hospital. It should give staff the power to enforce acceptable use of information technology, the

[73] See *Information Security Management: NHS code of practice* (April 2007) Department of Health. *NHS Information Governance: Information Risk Management,Guidance: Social Interaction- Good Practice* (February 2012) Department of Health Informatics Directorate

internet and social media. It would need to be reviewed and updated regularly in light of the changing information technology landscape. The information policy lead also emphasised the fact that the use of the internet and information technology by patients and visitors represents a business risk to hospital trusts, especially in relation to their reputation, and trusts should manage it at board level.

12.101 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful[74].

Recommendation

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

The management of human resources

12.102 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. NHS Employers' employment check standards make clear that NHS trusts must seek written confirmation from a supplier of contract or agency staff that employment checks have been undertaken and that monitoring of compliance with this requirement must be part of scheduled auditing arrangements. Providers of contract or agency staff who have a national framework agreement with Crown Commercial Services (CCS) are required to give assurances about

[74] Teenage Cancer Trust's policy and terms and conditions for the use of the internet and social media by patients and their families offer a useful model.

their pre-employment processes and are subject to random auditing by CCS. However, a number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training. They told us the tendency towards a high turnover among contract and agency staff compounded their concerns. They questioned whether hospital organisations were adequately monitoring whether contractors fulfilled their contractual obligations in these respects.

12.103 The hospitals we visited sought to reassure us that they had processes to check and follow up on their contractors' compliance with their obligations in relation to the staff they supplied. One hospital also told us that all its contract staff were in any event required to undergo the hospital's own training. Nevertheless, in light of the Savile affair, and given the risks and sensitivities associated with recruiting and managing hospital staff, we urge all hospitals to review their processes for ensuring and checking that contract and agency staff are subject to appropriate recruitment and employment processes and receive adequate training.

12.104 Our investigations and the Leeds investigation have also highlighted the fact that in some hospitals responsibility for certain employment and human resources (HR) matters lies other than with the hospital's HR department. One hospital we visited explained that their contract staff, which includes their estates and security staff, were solely the responsibility of the estates and facilities department. The director of workforce and organisational development told us:

> *"It is all done through our director of estates and facilities, so a lot of the contracts that we put out and the tender requirements that go out include a requirement for staff to be CRB checked and they run internal processes within estates and facilities to check and follow up on that."*

12.105 Similarly, the Leeds investigation report found that the trust directly employed portering and security staff but they were subject for historical reasons to separate HR processes managed by the estates and facilities department. The processes were parallel to those operated by the main HR department for all other staff but the investigation team concluded:

> *"…we are concerned that separate processes may make it difficult for the board to receive an overall assurance that recruitment and employment practices are operating in a consistent and robust manner. Consideration should be given to establishing a unified HR process across the organisation which fulfils the recruitment and employment requirements for all trust employees".*[75]

12.106 We believe the Leeds investigation team was right to identify the need for professionalism and consistency across a hospital trust in relation to the recruitment, checking and training of staff, including contract and agency staff. We understand that many organisations manage their HR function on a "business partner model" with a central HR function responsible for policy, strategic and corporate matters and separate HR managers working within and as part of separate departments. But even within this model we believe that organisations can and should ensure that processes are operated consistently and rigorously across all their departments and functions. And overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director. In keeping with this approach, we also believe it is right that HR processes expected of third-party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers.

Recommendations

R10 NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

[75] Leeds investigation report, p.179

13. Raising complaints and concerns

13.1 A number of those we interviewed, including the former director of the Crown Prosecution Service, talked of their concerns about the difficulties that victims face in reporting abuse, and the relatively low numbers of cases of abuse that result in prosecutions.

13.2 A recent report for the NSPCC found that many disclosures of abuse by children are either not recognised or understood or are dismissed or ignored.[76] The report authors say that their research "*had highlighted the need for greater awareness about the signs of abuse, that children do disclose but we don't hear those disclosures*".[77] Likewise, representatives of the Patients Association and of Age UK talked to us about the reluctance of older people to raise concerns about their care and in particular issues of abuse. Representatives of Mencap told us about the difficulties associated with enabling people with learning difficulties to report their concerns and with identifying when people with learning difficulties have been abused.

13.3 The difficulties that Savile's victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations. They show that few of Savile's victims felt they could or should tell anyone. Most of those who did say something found that they were not believed or were ignored.

13.4 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them.

13.5 Rt Hon Ann Clwyd MP and Professor Tricia Hart set out in the report of their review of the NHS complaints system[78] what is needed of an effective complaints system. The

[76] Allnock, D. and Miller, P. (2013*) No one noticed, no one heard: a study of disclosures of childhood abuse.*
[77] *Ibid.* p.56
[78] (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System.*

following points in that report have particular resonance with the concerns expressed to us about the difficulties people face in reporting incidences of sexual abuse:

> *"Patients want a complaints system that is easy to understand and to use; that is easily accessible and does not require any particular expertise to navigate; and that takes account of the difficulties many people face in expressing themselves or giving evidence, particularly at times of stress, ill health or in bereavement"*[79]
> *"The way that complaints are handled should be sympathetic and sensitive and not seek to reduce, deny or marginalise people's feelings"* [80]

13.6 The report makes a number of recommendations aimed at improving the present arrangements for managing complaints and whistleblowing about the quality of treatment or care in NHS hospitals. Some of the recommendations seem to us particularly helpful in promoting the sensitivity within organisations necessary to encourage the reporting and appropriate handling of complaints about sexual abuses and we endorse them:

- *"There should be annual appraisals linked to the process of medical validation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff*
- *Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained*
- *PALS should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital*
- *Every trust should ensure any re-branded patient service is sufficiently well sign posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue*
- *Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem*

[79] (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System.* p.20
[80] *Ibid.* p.21

- *Staff need to record complaints and the action that has been taken and check with the patient that it meets their expectations*
- *Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively"*[81]

13.7 In his recently published review, Sir Robert Francis QC considers at length how the NHS can develop a more open and honest reporting culture generally. His findings and recommendations accord with and enlarge upon much of what we learnt from our investigations.[82]

13.8 In section 12 above we considered how, as part of a robust overall safeguarding system, organisations need to be responsive when people make complaints and raise matter of concern. In the following sections we consider other more specific matters that we believe will encourage staff, patients and others to raise the alarm in particular about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

13.9 Many people we interviewed told us that the term 'whistleblowing' to cover policies aimed at encouraging staff and others to speak out about matters of concern particularly in relation to abuse was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised. They told us that 'whistleblowing' also heavily implied the possibility of legal proceedings. Vida Morris, the deputy director of clinical governance at Northumberland Tyne and Wear NHS Foundation Trust, said:

> *"From a staff perspective...I don't think the term whistleblowing is particularly helpful. It has very negative connotations to it and I think it is sometimes obstructive in terms of people feeling able to come forward and raise concerns."*

[81] (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System.* p.32 to 34
[82] Sir Robert Francis QC (February 2015) *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS.*

13.10 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term 'whistleblowing' and had changed the name of their policy to 'raising concerns policy' or were using the term 'raising concerns' in conjunction with 'whistleblowing'. From the perspective of seeking to encourage people to disclose the sensitive and difficult matter of abuse, we suggest that all NHS organisations need to ensure that the title and content of their policy makes clear that it applies to raising all and any concerns, whether or not they amount to matters that some might describe as whistleblowing.

13.11 The investigations at Leeds and Stoke Mandeville found widespread gossip and talk and complaint among staff at those hospitals about Savile's inappropriate behaviour as a porter and his promiscuity and sexual harassment of female staff. But it seems that the gossip, talk and concerns of staff were not brought to the attention of senior managers. As a result managers did not prevent him from continuing to volunteer at the hospitals. These findings prompt us to suggest that NHS organisations drafting their policies and communicating with their staff about raising concerns must be explicit that staff should raise all potentially serious matters, even if they do not have hard evidence to justify their concerns. Staff should be trained and encouraged to report any matters which indicate a risk of harm to others, even if what they pass on appears to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

13.12 We discuss above the organisational values and culture required to underpin an effective safeguarding system. Certain other factors encourage the development of a culture that more specifically supports people to raise complaints and issues of concerns.

13.13 The investigations at Leeds and Stoke Mandeville found that rigid and hierarchical lines of accountability, as well as 'silo-based' management and complaints handling arrangements, deterred staff and patients from raising concerns about Savile. They also meant that the complaints and matters of concern raised were not dealt with appropriately. In particular they were not escalated to senior managers.

13.14 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. The director of workforce at one NHS

trust we visited discussed with us the outcomes of a listening exercise undertaken with staff to discuss how they felt about challenging colleagues in higher professional roles. She told us:

> *"Some staff are less confident because they thought others would do [the challenge]. That made us realise that we cannot have these hierarchical differences; if people have a concern they need to raise it regardless of their banding or professional role. Tackling it involves developing a culture and the work that we are doing involves trying to breakdown some of the silo working across the whole trust engendering a more supportive culture."*

13.15 Another hospital we visited was making generally commendable efforts to support staff to raise concerns. Nevertheless, junior nurses acknowledged that they would still be reluctant to raise concerns that amounted to a challenge to those they saw as in positions of authority. What we found is echoed in the Stoke Mandeville investigation report which contains the following pertinent comment:

> *"When interviewed by the Investigation several witnesses felt that, even today, they would be reluctant to raise concerns pertaining to staff performance for fear of reprisals".*[83]

13.16 What we heard and what we learnt from the Savile investigation reports make clear that people do not feel comfortable challenging those they see as in authority and hierarchies within hospitals are a barrier to staff raising their concerns. A number of those we spoke to said it was important to encourage staff to overcome their natural reluctance to challenge or question the behaviour of others that they see their managers as present and approachable. As Lynne Wigens, director of nursing at Ipswich put it *"I think it is really important that the whole board gets out and about and hears directly from staff...you don't have to say very much for people to tell you exactly what is going on and what it is that is concerning them, but you do have to be out there to hear it."*

[83] Stoke Mandeville investigation report, para. 14.12

13.17 The director of nursing and clinical governance at the Royal Brompton and Harefield NHS Foundation trust wrote in answer to our call for evidence:

> *"The higher profile of safeguarding matters in society and the media as well as the NHS has led to reports and investigation of more concerns than in the past and I believe that staff in particular are clearer about their responsibilities for this aspect of care of patients, visitors and colleagues. The culture of the organisations plays a big part in this and ensuring that all staff are approachable and supportive and know what to do. This is a big challenge. The way senior staff react to a person who reports, and how they investigate and act thereafter I believe are key determinants that at best encourage and at worse deter reporting of concerns."*

13.18 Helene Donnelly, who spoke to us about her experience of raising concerns about the standards of care when she was employed as a nurse by Mid Staffordshire NHS Foundation Trust, emphasised the need for all managers to be trained to deal positively and appropriately when matters of concern are reported to them. She told us that the culture in NHS organisations needs to be one where the raising of matters of concern is "*not only expected, but is accepted as well*". Sir Robert Francis QC made the same point in an interview with us:

> *"It doesn't matter how many problems or issues you have as an employer with your informant-it may be an incompetent surgeon...or whatever else it is- you must listen to what they say where it raises an issue for patient safety.*
> *....If what is being said is potentially very serious or could lead to serious results then something must be done about it, instead of it just being brushed off as an inconvenient piece of information."*

13.19 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so. We heard of a good example of an organisation giving staff support in this way at one trust we visited. We were told about staff who had been disciplined following allegations against them of misconduct. The trust introduced managers from other parts of the organisation to the ward in question to ensure that staff and patients who had raised the alarm were not subject to retribution.

13.20 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had changed markedly in recent times. They told us there was an increasing willingness to speak out against instances of such behaviour. One director of workforce told us:

> *"I think we have seen a massive social shift over the last 20 years. People are much more willing to speak out. There's an awful lot more people raising grievances about sexual harassment whereas 10 years ago that was less likely..."*

13.21 A director of nursing told us *"there has been such a lot of heightened awareness about the importance of speaking up when you feel things aren't right and something is odd."* She went on to give us a good example of a recent case in her organisation in which a young female member of staff challenged the sexually inappropriate behaviour of a male colleague, which ultimately resulted in the male colleague being subject to disciplinary action.

13.22 Developing a culture that supports staff to raise concerns is not a simple task. It requires organisations constantly to be clear about values and expectations and regularly to reinforce the message that all staff have an obligation to report concerns and matters that may be amiss. Organisations also need to keep reviewing and refining the way they encourage and support staff to fulfil that obligation. In addition, managers need to ensure that they respond positively and appropriately when concerns are raised with them.

Providing opportunities for staff, patients and others to raise concerns

13.23 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. Birmingham Children's Hospital NHS Foundation Trust particularly impressed us with their imaginative and comprehensive suite of methods for staff, patients and their families to report on their experiences in the hospital and raise matters of concern. The chief nurse at the trust told us:

"the safeguarding process is just one route of raising a whole variety of concerns... people may not think from a harassment perspective to go to safeguarding . They may think HR. But it is our job to make sure there are lots of routes but predominantly that it is heard- that's the important thing, that we hear it ...and it isn't dismissed"

13.24 Staff at the trust told us that its arrangements included an intranet page where staff could report any issues anonymously. They had an annual open event for all staff at which they could raise issues with the whole executive team. In response to the reports in relation to Savile and Mid Staffordshire, they had set up an anonymous helpline for staff to report concerns. They had held a series of special staff forums where staff had been invited to comment on how able they felt to raise concerns. Posters and leaflets on wards told patients they could raise complaints or any issue of concern by filling out cards available on wards, by email, by text and on the trust's patient feedback app. The lead for patient experience and participation also told us how they visited some patients after they had left the hospital to gather their stories for feedback to the board and senior managers. She also described how they contacted some patients before admission to the hospital and asked them to provide feedback on their experience of their care on a "mystery shopper" basis. In addition, the trust had recently established a Trainees Advocacy and Liaison Service (TALS) based on and managed by their Patient Advocacy and Liaison Service and aimed at getting junior doctors on placements to report their concerns. Given that trainees are close to the trust operations and likely to be less inhibited than permanent staff in raising concerns, we commend the trust for trying to tap into what could be a valuable source of information.[84]

13.25 Other hospitals told us they had set up email addresses to allow staff to raise their concerns anonymously. At Heatherwood and Wexham Park NHS Hospitals Foundation Trust, the former chief executive told us of her concern that patients and relatives had no channels through which to raise issues they wanted resolved out of hours. In response, she had instigated a poster campaign that identified how they could contact a duty nurse and an on-call manager. At Ipswich Hospital NHS Trust we heard about a helpline of volunteers trained to support employees, which was a conduit for raising concerns.

[84] See Sir Robert Francis QC's "*Freedom to Speak Up*" review p 177 on the need for particular measures to encourage and support students and trainees to raise matters of concern.

Raising concerns - conclusion

13.26 Our evidence suggests that many NHS hospitals are trying to promote the values and arrangements that encourage people to voice their concerns. But, as Sir Robert Francis QC's "*Freedom to Speak Up"* review has found, there is more that could and should be done. We would urge all NHS hospital organisations to continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients, especially from their most junior staff and their most vulnerable patients who are at greatest risk of being victims of abuse.

Mandatory reporting

13.27 Some people told us that in light of the Savile case and other recent sex abuse scandals they would welcome the introduction of a statutory duty to report suspicions about child abuse, in the same vein as the legislation applicable to Northern Ireland which makes it an offence for a person who knows or believes that any offence has been committed not to report that information[85]. Most of those who discussed the issue with us were, however, against mandatory reporting. They argued that victims would be inhibited from confiding in others and reporting abuses because they could no longer do so in confidence and because they would lose choice and control over their circumstances. They also told us that professionals and others would be inhibited from sharing and discussing their suspicions about abuse for fear that the police would necessarily become involved in matters that might not justify such an intervention.[86]

13.28 Mandatory reporting is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal. This is a sensitive and specialist subject that deserves to be widely consulted upon and given thorough consideration and we welcome the government's recent announcement of a public consultation on the subject.

[85] Criminal Law Act (Northern Ireland) 1967 s 5 (1)
[86] See further arguments set out in NSPCC Policy Position Paper (January 2014) *Mandatory reporting: A consideration of the evidence.*

14. Fundraising and charity governance

14.1 The report of the Savile investigation at Stoke Mandeville hospital makes clear that Savile's fundraising on behalf of the National Spinal Injuries Centre (NSIC) played a significant part in maintaining and enhancing his access and influence. The Leeds investigation team commented that Savile's *"celebrity status and pursuit of publicity combined with his record of fundraising...are likely to have given Savile greater longevity within the Infirmary and access and influence than either of these factors alone might have done."*[87]

14.2 We can find no other example in modern times of an individual fundraiser or celebrity having so much unchecked influence in NHS organisations as Savile. But his case does raise the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in them.

Background

14.3 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. NHS charities are bound by and subject to the NHS Act 2006 as well as by charity law.

14.4 Most NHS charities have a corporate trustee governance model under which the property of the charity is held by the NHS hospital itself and the hospital's board of directors act collectively as trustee for the charitable property given to it[88]. A small number of NHS charities have a body of individual trustees appointed by the Secretary of State for Health to carry out their trustee functions and two hospitals[89] have recently been granted the right by the Secretary of State to establish an independent company limited by guarantee to act as trustee of their associated NHS charities.

14.5 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. This review was

[87] Leeds investigation report, p.75
[88] See The National Service Act 2006
[89] Barts Health NHS Trust, Royal Brompton and Harefield Foundation NHS Trust

established in part in response to pressure from some larger NHS charities for a governance model that would give them greater independence from their associated NHS bodies and the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate trustee of their charitable funds established and regulated under NHS legislation if they wish to do so. The government has repealed the provisions allowing for the appointment of charitable trustees by the Secretary of State for Health and is requiring charities with appointed trustees to choose whether to transfer their funds to a new independent trust or to hold them as an NHS charity with a corporate trustee governance model.[90]

Fundraising by NHS charities

14.6 Our investigations revealed wide variation in the sums generated by hospitals from charitable fundraising. Annual accounts show that nearly half of the £368m raised by the 254 NHS charities in 2012/2013 was raised by and benefited six large high-profile hospital trusts.[91] By far the largest income from charitable sources is received by Great Ormond Street Hospital which in 2012/2013 received £70m, equivalent to nearly 25 per cent of the hospital trust's income from the NHS budget for patient care. In the same year the University College London Hospitals Charities had income of £35.9m and the Christie Hospital Charitable Fund received £13.2m. But most hospitals receive much smaller sums from charitable sources: 183 NHS charities reported annual income in the year 2012/2013 of less than £1m, with 120 of them receiving less that £400,000.[92] One district general hospital we visited told us they undertook no active fundraising.

[90] Department of Health (March 2014) *Review of the Regulation and Governance of NHS Charities; Government response to consultation*.
[91] Great Ormond Street Hospital Children's Charity; University College London Hospitals Charities; Barts and the London Charity; The Christie Hospital Charitable Fund; and Guy's and St Thomas' Charity, the Royal Marsden Hospital Cancer Charity. Information collated from annual accounts by the Association of NHS Charities.
[92] Information collated from annual accounts by The Association of NHS Charities.

Savile's fundraising

14.7 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. They had individual trustees, including Savile, and were bound by charity law. Many individual charitable trusts like those Savile established raise funds for NHS organisations but sit outside the governance arrangements of the NHS. Many are established and managed by former patients, their families or their friends and undertake fundraising for hospitals or particular hospital services.

14.8 Savile's use of his fundraising at both Stoke Mandeville and Leeds to promote his own projects and to maintain his own access and influence prompted us to consider how NHS hospitals and their associated NHS charities ensure that their own fundraising is subject to good governance, and how they ensure appropriate management of relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

Elements of good governance

14.9 We interviewed Marianne Fallon, UK head of charities at the accounting firm KPMG, and Caroline Lane, an experienced professional fundraiser who has led a number of high-profile NHS charitable fundraising projects. Both told us that the disparity in charitable funds raised by NHS charities was matched by variable standards of professionalism and governance arrangements; those charities that raised most were likely to have the greatest interest in and capacity for ensuring that they undertook their fundraising and managed their charitable funds to the highest professional standards.

14.10 Caroline Lane told us:

> *"There is no hard and fast rule with all these charities because there are such different levels of sophistication within the individual hospitals and their charities, there isn't a standard format that everyone works to for fundraising"*

14.11 Marianne Fallon, UK head of charities at KPMG, considered with us the elements required to ensure that fundraising by NHS charities was managed *"from a best practice perspective".* The first element was proper risk management to ensure not only the protection of charitable assets and funds raised but also protection of the good name and reputation of the charity. Marianne Fallon said:

> *"from a best practice perspective...fundamentally it's about risk management for me. If you are entering a relationship with somebody who is either going to be raising money for you on your behalf or indeed giving you some kind of income stream, whether it is corporate sponsorship or whatever, you would expect that there would be an appropriate degree of rigour around the risk assessment of that...because ultimately under charity law the charity trustees have a legal duty to protect the assets of the charity. That isn't only about making sure that the pounds and pence are spent on the right thin*g. *The biggest asset the charity has, obviously, is its brand and its reputation....sometimes a charity can be playing catch up because someone may have publicly said "I am raising money for Charity A" without that charity having been aware of it".*

14.12 The fate of Savile's own charities graphically illustrates the damage that can be done to a charitable cause by association with a person held in disrepute. Savile's nephew, Roger Foster told us:

> *"There is about, I don't know, £40million probably in the various charitable trusts. We cannot do anything with it at the moment because nobody wants to know. You ring up and say* 'I'm a trustee of the Jimmy Savile Charitable Trust'*.* 'Thank you very much' *and the phone goes down again, they are not interested because it is toxic. If you take money from that some other benefactor might turn around and say,* 'Well, I'm sorry we are pulling out because you are taking money from there'*. It is a very tragic state of affairs, it really is because there is money there that could be so useful to help people."*

14.13 In considering the risks to an NHS charity and to the NHS organisation it seeks to benefit, trustees and hospital management must look at their relationships not only with celebrities but also with major donors, commercial partners and with other charitable organisations and interests that benefit the charity or the hospital or occupy its site.

14.14 Two NHS hospitals that we spoke to received a significant income from their NHS charity and shared with the charity clear and documented policies and risk-assessment processes for managing these relationships and for protecting their organisation's brand and reputation. However, this was not the case with most of the organisations we had contact with, though some were beginning to examine and formalise their arrangements in the light of the Savile affair.

14.15 For example, one high-profile NHS organisation that used celebrity endorsement in its publicity campaigns and another which had significant associations with celebrities and commercial partners, and a large income from charitable sources received via an associated NHS charity, had no formal policies for managing and assessing the risks to their 'brand' and their relationships with celebrities and others. They did not include the issue of brand and reputation management in their risk registers. In the case of the latter organisation however, the related NHS charity did operate under a policy on the acceptance of charitable gifts and did refer doubtful gifts to an ethics review group. The head of corporate affairs at one of these organisations explained that brand management was the responsibility of the organisation's communications department and the board as a whole discussed issues such as the type of commercial ventures the organisation would be prepared to enter into:

> *"We've had discussions about what countries we would be prepared to do business with. We have a general policy that we won't deal with people who don't have a good record in human rights including torture...The brand is protected and is quite proudly protected by the board and on the board's behalf by the communications department".*

14.16 He confirmed that the brand was not included on the risk register, which he explained thus:

> *"I don't think the brand is regarded as a general risk on the risk register because we haven't any track record of the brand actually being abused in any way that cannot be dealt with and nipped immediately in the bud."*

14.17 A number of the management teams at other NHS hospital trusts we spoke to said they had informal discussions about reputational risks as necessary, including whether to form associations with individual celebrities, donors and commercial partners. Some said

they had no need of formal arrangements in this respect because of the limited nature of their fundraising activity. We believe, however, that staff with little or no experience of managing relationships with celebrities, major donors or commercial sponsors are at greatest risk of being 'star struck' and of mishandling such relationships and must be able to refer to guidance in a formal policy.

14.18 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent. Moreover, most hospitals, including those with limited fundraising activity, told us they received and benefited from occasional visits from celebrities simply for the purpose of boosting staff and patient morale.

14.19 We believe that most NHS organisations and their linked NHS charities are exposed, and will become increasingly exposed, if they do not have clear policies and procedures for assessing and managing the risks to their brand and reputation from associations with celebrities, donors and others.

Recommendation

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

14.20 The second element of good governance Marianne Fallon spoke about was the need for NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes. She told us:

> *"that is not to say there can't be some - and often you would expect there to be some - representation from the NHS trust itself, but the board of the charity should ultimately be comprised so that it can demonstrate and is in practice independent and its own decision - maker."*

14.21 She went on:

> *"I suppose one of the challenges for any charity is that they can clearly demonstrate in practice the power of the board from a governing perspective is working appropriately, i.e. it isn't one person who is effectively driving through decisions and the rest of the board are just nodding through their wishes. That goes back to each individual trustee's responsibilities under charity legislation to individually - and jointly, but individually - make decisions in the best interests of the charity, protect the assets of the charity and make decisions which balance the interests of the current beneficiaries with those of the future."*

14.22 Whichever of the models referred to in paragraph 14.5 is adopted for the governance of NHS charitable funds, trustees will need to ensure and demonstrate that they act appropriately, that one trustee does not dominate their decision-making and that the decisions are guided only by the best interests of the charity.

14.23 As we explain, the Jimmy Savile Stoke Mandeville Hospital Trust was not an NHS charity but its associations with Stoke Mandeville Hospital clearly demonstrate the dangers for any NHS organisation of being associated with a charity in which one individual dominates decision-making and uses their control over charitable funds to further their own personal agenda and influence.

14.24 The Stoke Mandeville investigation report shows how Savile's position in the Stoke Mandeville Hospital Trust gave him the opportunity to interfere in issues ranging from the choice of contractors used to build the NSIC to the type of carpet laid in the centre, sometimes with unhappy consequences. And his control over the significant charitable funds held for the benefit of the hospital allowed him to maintain a presence and influence in that organisation long after he had become unwelcome there. The Stoke Mandeville investigation report says:

> *"Witnesses told the Investigation that between 1983 and 1990, Savile demonstrated virtually uncontested authority and control at the NSIC…It had been thought that Savile's intense interest in the NSIC would decrease once the building had been opened; this did not happen. Instead Savile took up residence in his own office suite at the NSIC from where he 'held court' and continued to manage the Jimmy Savile Stoke Mandeville Trust Fund…From an early stage Savile was of the*

view that he 'owned' the NSIC and as such had the right to manage its affairs as he saw fit. Savile was able to maintain a tight grip on affairs as the NSIC continued to be dependent upon his Charitable Trust Funds."[93]

14.25 Besides the governance considerations we discuss above, the best interests of an NHS charity and the fulfilment of its objectives also require a shared understanding between a donor charity and the hospital management about the service needs and priorities of the hospital. As Caroline Lane put it:

" it would be an absolute disaster if we raised millions of pounds for [an] item of equipment and then found that the hospital couldn't use that item because a proper business case had not been put together that looked at things like ......staffing, training of staff, maintenance, all the extra costs that carry on.."

14.26 We heard of instances of tensions between NHS charities and the hospitals they supported over the way charitable funds were applied. Marion Allford, an experienced professional fundraiser who now acts as a consultant for fundraising projects, suggested that such tensions were quite common. Amanda Witherall, the chief executive of the Association of NHS Charities, pointed out that the fault can lie with either party:

"Unfortunately there are some instances where tension exists between the NHS charity and the parent hospital's board. Sometimes this is down to poor communications and lack of engagement and either party (or both) can be at fault here. This can result in the hospital board getting frustrated and thinking 'the charity is just hanging on to the money and not spending it as they should'*. Equally the charity often feels the hospital just sees it as a 'slush fund' to be used whenever things get a bit tight and don't fully appreciate the need to plan charitable expenditure properly."*

14.27 The key to minimising the risk of such tensions is continuous engagement between a hospital trust's managers and its charity trustees to ensure a common understanding of the needs and priorities of the hospital and where the charitable funds can be appropriately applied to best effect to support them. As William Colacicchi, a solicitor and

[93] Stoke Mandeville investigation report, paras. 12.75-12.76

chair of the Association of NHS Charities, put it: *"it is about communication"* and *"encouraging people to the right behaviours"*. He also pointed out:

> *"As charity trustees, you already have a duty to spend your money; as a matter of law you are not allowed just to sit on it, you have to spend it. Generally, you have to spend it within the [the hospital] trust, so you actually have a duty to talk to your [hospital] trust to work out how to spend it effectively. I'm not sure there is additional legislation or rules you can apply which will really enhance that duty, because I think it already exists and it is a question of highlighting rather than expanding it."*

14.28 Marion Allford gave us an example from a London hospital of good practice for ensuring that the hospital and its NHS charity worked together constructively in the interests of patients.

> *"There were joint steering groups with the chairman and chief exec and medical director and the key trustees coming together at least twice a year. The purpose of these meetings was for the hospital to keep the trustees up to date with the charity's progress and how charitable funding had been spent, to be informed on the key issues and future plans and to explain where charitable funding would be most beneficial for patients. This allowed trustees to question the hospital representatives on these issues and to discuss with them the options for future charitable projects, before deciding which projects they would select for fundraising or grants. If trustees are kept in tune with the hospital's vision for the future, the role they can play can be maximised"*

14.29 The Stoke Mandeville investigation report shows that tensions arose between Savile and managers at the hospital about the use of charitable funds and that Savile was able to use his control of charitable funds inappropriately to influence the way services were provided. In the light of this we would urge all charities linked to NHS hospitals to consider whether they are structured and at all times operate in such a way as to further their charitable purposes. We also urge NHS hospital trusts and their associated NHS charities to consider how best to engage with each other to ensure a common understanding and respect for each other's purposes and priorities.

15. Observance of due process and good governance

15.1 As the investigations at Broadmoor and at Stoke Mandeville show, Savile's involvement with those hospitals was supported and facilitated by ministers or senior civil servants. At Broadmoor they appointed him to the task force that ran the hospital for a period between 1988 and 1989. At Stoke Mandeville they appointed him to oversee the fundraising for and the building of the new National Spinal Injuries Centre. In appointing Savile to these roles and in allowing him the licence and free rein he had in exercising these roles ministers and/or senior civil servants either overrode or failed to observe accepted governance processes. A good example of the outcomes of this was that the group managing the rebuilding of the NSIC, led by Savile, was able to ignore usual procurement procedures in appointing contractors, and two of the trustees of the charitable funds which financed the building were involved in awarding contracts to their own firms.

15.2 It is not within the scope of our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or to invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

15.3 We make recommendations in this report which are aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. They include recommendations that celebrities should not be exempt from standard procedures governing access to patients; that contacts between NHS organisations, including NHS charities, and celebrities should be subject to careful consideration and risk management; and that all volunteers should be subject to proper selection, supervision and management processes. But ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations, and they should not undermine the processes of good governance and local management.

16. Ensuring compliance with our recommendations

16.1 The following recommendations are addressed to:

- Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts;
- The Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of childen and adults.

Recommendations

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts, (and where applicable, independent hospital and care organisations) comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11 above.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12 above.

17. Conclusions

17.1 Savile was a highly unusual personality whose lifestyle, behaviour and offending patterns were equally unusual. As a result of his celebrity, his volunteering, and his fundraising he had exceptional access to a number of NHS hospitals and took the opportunities that that access gave him to abuse patients, staff and others on a remarkable scale. Savile's celebrity and his roles as a volunteer and fundraiser also gave him power and influence within NHS hospitals which meant that his behaviour, which was often evidently inappropriate, was not challenged as it should have been. Savile's ability to continue to pursue his activities without effective challenge was aided by fragmented hospital management arrangements; social attitudes of the times, including reticence in reporting and accepting reports of sexual harassment and abuse, and greater deference than today towards those in positions of influence and power; and less bold and intrusive media reporting.

17.2 While it might be tempting to dismiss the Savile case as wholly exceptional, a unique result of a perfect storm of circumstances, the evidence we have gathered indicates that there are many elements of the Savile story that could be repeated in future. There is always a risk of the abuse, including sexual abuse, of people in hospitals. There will always be people who seek to gain undue influence and power within public institutions including in hospitals. And society and individuals continue to have a weakness for celebrities. Hospital organisations need to be aware of the risks posed by these matters and manage them appropriately.

17.3 In this report we describe the values, management arrangements and processes that organisations need to have in place if they are to tackle the issue of abuse in hospital settings. We set out what we have found out about NHS hospitals' present values, arrangements and processes and the weaknesses in them. We make recommendations which we hope will lead to all NHS hospitals reviewing their arrangements and to the tightening up of procedures and processes. However avoiding events similar to the Savile case depends in large part on human behaviour and on individuals taking responsibility for ensuring that they and those around them, whatever their role and status, adhere to agreed policy and do not overstep the boundaries of sensible and acceptable behaviour. This will not result from merely changing policies and procedures or a one-off exercise to examine and assure present safeguarding arrangements: it requires repeated

reinforcement of messages, awareness - raising and training, as well as regular ongoing testing of the effectiveness and relevance of safeguarding arrangements.

17.4 Our report is only one of several that have recently been commissioned into cases of sexual and other abuses and the handling of them by public bodies. We have endeavoured to share our thinking and findings with those who have undertaken or are undertaking such other investigations or with a remit to oversee relevant areas of public policy and services. We hope to continue to engage with them in order to ensure a coherent and effective response to all the issues of abuse that are being exposed and examined, and that the recommendations that we and others make are properly implemented.

Appendix A

Biographies

Kate Lampard CBE

Kate Lampard spent 13 years in practice as a barrister, before moving into the public sector, where she held a number of non-executive appointments. She now undertakes investigation and consultancy work related to organisational, management and service arrangements and their effectiveness.

Kate has previously been the chair of the South East Coast Strategic Health Authority, vice chair of the South of England Strategic Health Authority and a non-executive director and vice chair of the Financial Ombudsman Service Limited. She is a trustee of the Esmee Fairbairn Foundation.

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's managing partner with an active role in leading complex consultancy. He has recently advised the Jersey government about the inquiry into historical child abuse. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

Appendix B

Letters from Right Honourable Jeremy Hunt MP, Secretary of State for Health, to Kate Lampard

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
healthsofs@dh.gsi.gov.uk

IMC: 8733

Kate Lampard

29 October 2012

Dear Kate,

OVERSIGHT OF THE DEPARTMENT OF HEALTH AND NHS REVIEWS INTO JIMMY SAVILE

You have been in discussion with Una O'Brien about providing oversight of the Stoke Mandeville, Leeds General Infirmary and Broadmoor inquiries as well as the Department of Health's inquiries into the appointment and role Savile held at Broadmoor Hospital. I am very grateful that you have agreed to take on this important role.

I would like you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interests of patients.

Your appointment will end once internal inquiries in the Department of Health and the trusts have been pursued, an agreed conclusion and account of events has been reached and you have assured me as to the robustness of the process that was followed to reach these conclusions. Any potential other work beyond that will be determined at the time. It is planned that your advice on the robustness of the reviews undertaken and the reviews themselves will be made available to the public.

I have instructed officials to give you the support you need on this and I will make myself available to you should you so wish.

Yours ever

Jeremy

JEREMY HUNT

SC2910123

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

POC1_738163

Kate Lampard

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

Dear Kate,

12 NOV 2012

Thank you for sharing the letters that you sent to Stoke Mandeville Hospital, Leeds General Infirmary, Broadmoor Hospital and the Department of Health, outlining your expectations of them in their reviews into Jimmy Savile's role and conduct in the organisations.

When I appointed you, I asked you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interest of patients. The framework that you have produced provides useful detail on how you will work with the organisations to do this. It clearly sets out your expectations and begins to shape the robust process that is required for this essential work.

It is inevitable that as you sample and assure yourself that the processes the organisations have followed are robust, you will identify themes. I would therefore like to ask you to look too at NHS wide procedures in the light of the findings and recommendations of the reviews you are overseeing once they have been completed, seeking expert advice as necessary, and see whether they need to be tightened. If so, I would very much like you to advise me on how any relevant guidelines or procedures need to be changed.

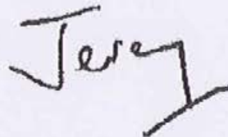
I am particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role.

Some individuals have recently raised concerns about whether your processes will be sufficiently independent. I am a clear that you are the right person for the job and you have my full confidence but I want to

make it explicit that I have appointed you in an independent capacity and I want to receive your independent views.

At the end of the process, I will publish your reports to me on both issues.

Yours ever,

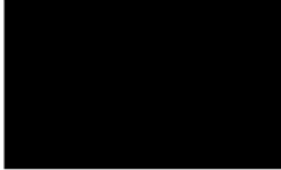


JEREMY HUNT

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

POC1_743970

Kate Lampard



Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

- 6 DEC 2012

Dear Kate,

The Police have recently brought it to the Department's attention that Jimmy Savile may have offended in a number of NHS institutions in addition to Broadmoor, Stoke Mandeville and Leeds General Infirmary.

From the very limited information they have shared at this stage, it appears that these involved one or two alleged incidents at each trust and they happened at institutions where Jimmy Savile did not have the responsibilities or access afforded to him at the organisations who are already conducting investigations. The Trusts, who have only recently been notified, are contacting the Police and will be investigating any allegations passed to them.

Unless further information subsequently comes to light I am not asking you to oversee these further investigations, but I would like to ask you to make contact with the organisations to ask for their conclusions about the circumstances of any abuse. I believe these may form an important part of your report into common themes relating to the abuse in the NHS. I attach a list of the information that we have at this stage and I will ask my officials to keep you updated if the police share further information.

Yours ever

Jeremy

JEREMY HUNT

Annex: Details provided by the police on 29 November regarding additional abuse in the NHS

	Institution	Number of offences
1	St James Teaching Hospital - same trust as the LGI	1
2	High Royds Psychiatric Hospital (closed 2003 and services moved into Leeds community services)	1
3	Dewsbury Hospital (now part of Mid Yorkshire NHS Trust)	2
4	Wycombe General Hospital (now part of Buckinghamshire Healthcare NHS Trust) – same trust as Stoke Mandeville	1
5	Great Ormond Street Hospital NHS FT	1
6	Ashworth Hospital NHS High Secure Unit*	1
7	Exeter Hospital (part of Royal Devon & Exeter Hospital NHS FT)	1
8	Portsmouth Royal Hospital (now closed and facilities part of Portsmouth Hospitals NHS FT)	1
9	Springfield Hospital (now closed and facilities part of South West London and St George's Mental Health NHS FT)	2 - *Offences were carried out by Johnny Savile (brother). Jimmy Savile is not known to involved.*

*At the time of the offence, Asworth Hospital NHS High Secure Unit was run by the Department of Health

One allegations only at this stage at each of the following

- Royal Victoria Infirmary, part of Newcastle Hospitals NHS FT
- Bethlem Royal and Maudsley Hospitals, part of South London and the Maudsley FT
- St Catherine's Hospital, Birkenhead, part of Wirral Community Trust
- Saxondale Mental Health Hospital, Notts (closed 1988)

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

POC1_822439

Kate Lampard

1 5 NOV 2013

Dear Kate,

JIMMY SAVILE INVESTIGATIONS: REVISED TERMS OF REFERENCE

I am writing to you with revised terms of references for your remaining work on the Jimmy Savile investigations in relation to the NHS, to reflect the recent announcement of potential further evidence relating to other hospitals.

On 14 October, I announced a further review of evidence by the Metropolitan Police in a Written Ministerial Statement (WMS). The review is nearing completion and in the WMS we committed to publish a list of further hospitals involved. In addition to the three main NHS investigations you are currently overseeing, I would be grateful if you could provide general assurance of the quality of all the reports relating to any new investigations, as well as the 10 NHS investigations on-going since April, in your final assurance report.

The Department of Health will be sending out guidance to the new Trusts about how they should proceed with their investigations shortly.

Verita has been asked to review reports for the 10 NHS investigations plus the investigation by Sue Ryder commissioned since April, as well as for any new investigations, in order to ensure a consistent and thorough approach is adopted.

As I made clear in the Written Ministerial Statement, the final reports of all the investigations will aim to be completed by June 2014, with publication sooner if that is possible.

I would also be grateful if your final summary report of lessons learned also included any learning from the 10 investigations and the new investigations.

I am grateful for your on-going work to ensure the investigations about Jimmy Savile's activities are as thorough as possible.

Yours ever

Jeremy

JEREMY HUNT

Appendix C

List of interviewees

The authors thank all those listed below for agreeing to be interviewed. The authors also thank the staff who managed their visits to the named hospitals.

This list gives job titles or descriptions correct at the date of interview.

- Donald Findlater, director of research and development, Lucy Faithfull Foundation
- Sir Thomas Hughes-Hallett, former chief executive, Marie Curie Cancer Care
- Caroline Lane, professional fund raiser
- Marianne Fallon, partner, UK head of charities, KPMG
- Maria da Cunha, director of people, legal and government and industry affairs, British Airways
- Paul Milliken, vice president – human resources, Shell UK
- Peter Carter, chief executive and general secretary, Royal College of Nursing
- Leonie Austin, director of communications, NHS Blood and Transplant
- David Evans, director of workforce, NHS Blood and Transplant
- Gary Hughes, assistant director of corporate communications, NHS Blood and Transplant
- David Spicer, former senior local authority lawyer, independent serious case reviewer
- Christine Humphrey, qualified nurse, former NHS manager, independent advisor on safeguarding and children's' services
- Hilary McCallion, former director of nursing and education, South London and Maudsley NHS Foundation Trust
- Jackie Craissati, consultant clinical and forensic psychologist, Oxleas NHS Foundation Trust
- Dame Donna Kinnair, worked in child protection services in the NHS for over ten years
- Nyla Cooper, programme lead for professional standards, NHS Employers
- Dean Royles, chief executive, NHS Employers
- The policy manager for the disclosure and barring service, Department of Health
- Amanda Witherall, chief executive, Association of NHS Charities

- William Colacicchi, chairman, Association of NHS Charities
- Janet Gauld, director for operations (barring), Disclosure and Barring Service
- Stephen Brusch, head of learning disability development, NHS England, London region
- Marion Allford, former director of the “Wishing Well Appeal” for Great Ormond Street Children’s Hospital
- Louise Hadley, director of fundraising and corporate affairs, The Christie NHS Foundation Trust
- Peter Davies, chief executive, Child Exploitation and Online Protection Centre
- Michael Watson, director of advice and information, The Patients Association
- Mary Cox, Age UK
- Richard Powley, head of safeguarding, Age UK
- Bella Travis, policy officer, Mencap
- Lynda Rowbotham, head of legal advice, Mencap
- Dr Jenifer Harding, independent chair, Sandwell Safeguarding Children and Adult Boards
- Deborah Kitson, chief executive, Ann Craft Trust
- Helene Donnelly, cultural ambassador, Staffordshire and Stoke on Trent Partnership NHS Trust
- Dr Justin Davis Smith, executive director of volunteering and development, National Council for Voluntary Organisations
- Peter Finch, chair, National Association for Healthcare Security
- Project manager, Department of Health
- Dominque Black, regulatory policy manager, Care Quality Commission
- Sir Robert Francis QC
- Peter Saunders, chief executive, National Association for People Abused in Childhood
- Carol Rawlings, chair, National Association of Voluntary Services Managers
- Richard Hampton, head of external engagement and services, NHS Protect
- Jane Walters, director of corporate affairs, King’s College Hospital NHS Foundation Trust
- Katherine Joel, head of volunteering, King’s College Hospital NHS Foundation Trust
- Reverend Adrian Klos, senior chaplain, Hull and East Yorkshire Hospitals NHS Trust
- Fiona Skerrow, voluntary services manager, Hull and East Yorkshire Hospitals NHS Trust
- The policy lead on governance policy – security and risk, Department of Health

- Deputy director people, communities and local government, Department of Health
- Social investment and volunteering policy manager, Department of Health
- Kristen Stephenson, volunteer management and good practice manager, National Council for Voluntary Organisations
- Elisabeth Harding, director family, volunteer and interpreter services, Boston Children's Hospital, USA
- Is Szoneberg, head of social action and volunteering Scotland and England, CSV
- Deputy director and head of social action, Cabinet Office
- Head of health, ageing and care, Cabinet Office
- Olivia Butterworth, patient and public voice and information, NHS England
- Kathrin Ostermann, director of supporter development, King's Health Partners
- Professor Alexis Jay, lead for the *Independent inquiry into child sexual exploitation in Rotherham*
- Chief Constable Simon Bailey, lead for child protection and abuse investigation, Association of Chief Police Officers
- Dave Shaw, deputy director of services, Teenage Cancer Trust
- Two witnesses who gave evidence but did not wish to be named

Savile's family

- Roger Foster and Amanda McKenna

Birmingham Children's Hospital NHS Foundation Trust

- David Melbourne, interim chief executive
- Michelle McLoughlin, chief nurse
- Pam Rees, named nurse for child protection
- Jane Powell, common assessment framework lead
- Louise Kiely, head of facilities
- Bryan Healy, head of risk
- Gaby Insley, head of communications
- Vikki Savery, fundraising manager
- Janette Vyse, lead for patient experience and participation
- Fiona Reynolds, deputy chief medical officer

- Gwenny Scott, company secretary
- Alison Stanton, patient relations manager
- David Scott, associate director of governance
- Theresa Nelson, chief officer for workforce development

Guy's and St Thomas' NHS Foundation Trust

- Eileen Sills, chief nurse and director of patient experience
- Peter Allanson, trust secretary and head of corporate affairs
- Deborah Parker, deputy chief nurse
- Mala Karasu, adult safeguarding lead
- Debbie Saunders, named nurse for safeguarding children
- Amanda Millard, group director operations
- Jayne King, head of security
- Ann Mcintyre, director of workforce and organisational development
- Anita Knowles, director of communications

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

- Philippa Slinger, chief executive
- Thomas Lafferty, director of corporate affairs
- Paul Rowley, director of facilities
- Mike Stone, fundraising and volunteers manager
- Jane Chandler, associate director of nursing

Ipswich Hospital NHS Trust

- Nick Hulme, chief executive
- Lynne Wigens, director of nursing and quality
- Beverley Rudland, complaints, PALS and bereavement team manager
- Sarah Higson, patient experience lead
- Dr Rob Mallinson, medical director
- Cindie Dunkling, named nurse for safeguarding children

- Julie Fryatt, director of human resources
- Linda Storey, trust secretary
- Sue Pettitt, clinical education and workforce development lead
- Jeff Calver, associate director of estates

Medway NHS Foundation Trust

- Mark Devlin, chief executive
- Dr Gray Smith-Laing, outgoing medical director
- Dr Philip Barnes, incoming medical director
- Dr Richard Patey, named doctor for child safeguarding
- Suzanne Winchester, named nurse for child safeguarding
- Steve Hams, chief nurse
- Tracey Sharpe, safeguarding vulnerable adults coordinator
- Suzanne Brooker, head of patient experience
- Zoe Goodman, voluntary services manager

Northumberland, Tyne and Wear NHS Foundation Trust

- Dr Gillian Fairfield, chief executive
- Angela Faill, caldicott police and court liaison lead
- Dr Suresh Joseph, executive medical director
- Gary O'Hare, executive director of nursing and operations
- Lisa Quinn, executive director of performance and assurance
- Vida Morris, deputy director of clinical governance
- Lisa Crichton-Jones, acting executive director of workforce and organisation

Appendix D

Kate Lampard's letter to all NHS trusts, foundation trusts and clinical commissioning groups (CCG) clinical leaders

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

NHS England Publications Gateway Ref No: 00056

To:
All Chairs and Chief Executives of
- NHS Trusts in England
- NHS Foundation Trusts in England
- CCG Clinical Leaders

Copies to:
- Chief Executives of Local Authorities in England
- CCG Accountable Officers
- NHS England Regional Directors
- NHS England Area Directors
- Barbara Hakin, NHS England

2 May 2013

Dear colleagues

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

You may recall that Sir David Nicholson wrote to you in December about my role in overseeing the NHS investigations into allegations of sexual abuse by Jimmy Savile at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor Hospital. Sir David asked you to review your own arrangements and practices relating to vulnerable people, particularly in relation to safeguarding, access to patients including that afforded to volunteers and celebrities and listening to and acting on patient concerns.

As the second stage of my oversight work, the Secretary of State for Health has asked me to identify the themes and issues arising from the three investigations and look at NHS-wide procedures in the light of the findings of those investigations.

I am therefore interested to hear from NHS staff about the following matters:

- safeguarding - how policies, procedures and practice take account of and affect patients, visitors and volunteers within NHS settings
- governance arrangements in relation to fundraising by celebrities and others on behalf of NHS organisations

- celebrities – the use and value to NHS organisations of association with celebrities, including in relation to fundraising, and the privileges, including access, accorded to them by NHS organisations
- complaints and whistle blowing – how and to what extent do policies and procedures and the culture of NHS organisations encourage or discourage proper reporting, investigation and management of allegations of the sexual abuse of patients, staff and visitors in NHS settings.

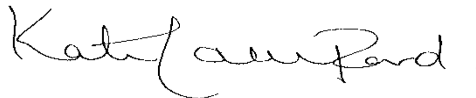
I would also like to hear from NHS staff if they have evidence or information about their own or their organisation's dealings with Jimmy Savile that has not yet been shared with any of the teams investigating the alleged sexual abuses by Jimmy Savile on NHS premises. Such evidence or information might include local factors or matters relating to the culture of the organisation that might have facilitated Jimmy Savile's abusive behaviour.

I should be grateful if you would use your own communication networks to let your staff know that they can contact me with information on the following email account:

It would be appreciated if you could send in any information by 30 June 2013.

Many thanks for your cooperation.

Yours sincerely



Kate Lampard

Kate Lampard, appointed to oversee the NHS and Department of Health investigations

Ed Marsden, managing partner of Verita, appointed to support the oversight work

Diary management c/o Denyse Lea
Telephone: Email:

Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: Fax:

Appendix E

List of organisations or individuals who responded to our call for evidence

NHS organisations

- 2gether NHS Foundation Trust
- Airedale NHS Foundation Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Birmingham Community Healthcare NHS Trust
- Black Country Partnership NHS Foundation Trust
- Bolton NHS Foundation Trust
- Brighton and Sussex University Hospitals NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Croydon Health Services NHS Trust
- Derbyshire Healthcare NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- East Cheshire NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Gateshead Health NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Ipswich Hospital NHS Trust
- James Paget University Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Lincolnshire Community Health Services NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust

- Mid Essex CCG
- Mid Staffordshire NHS Foundation Trust
- NHS Basildon and Brentwood CCG
- NHS Bexley CCG
- NHS Merton CCG
- NHS Sutton CCG
- NHS Walsall CCG
- NHS Waltham Forest CCG
- NHS Wandsworth CCG
- NHS West Essex CCG
- Norfolk and Suffolk NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- North Bristol NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Pennine Care NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal Brompton and Harefield NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Shropshire Community Health NHS Trust
- South Devon Healthcare NHS Foundation Trust
- St George's Healthcare NHS Trust
- Stockport NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- The Friends of Charing Cross Hospital
- The Hillingdon Hospitals NHS Foundation Trust
- The Pennine Acute Hospitals NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- The Walton Centre NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust

- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospital of North Staffordshire NHS Trust
- University Hospital of South Manchester NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Wirral Community NHS Trust
- Wye Valley NHS Trust
- Yorkshire Ambulance Service NHS Trust

Other organisations

- CPS strategy and policy directorate
- The Association of Directors of Children's Services Ltd

Individuals

- 10 x individuals

Appendix F

Documents reviewed

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- Regulated Activity - adults
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Hoyano, L. and Keenan, C. (2007) *Child Abuse; Law and Policy Across Boundaries*, Oxford University Press

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The Health Foundation (August 2013) *Quality improvement Made Simple: What every board should know about healthcare quality improvement.*

West Yorkshire Police (May 2013) *Report on Operation Newgreen (West Yorkshire Police's review of its contact with Savile).*

Appendix G

List of trusts visited as part of the work

- Birmingham Children's Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- The Ipswich Hospital NHS Trust
- King's College Hospital NHS Foundation Trust
- Medway NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust

Appendix H

List of investigations into allegations relating to Jimmy Savile

The three main investigations

- Stoke Mandeville Hospital – Buckinghamshire Healthcare NHS Trust
- Leeds General Infirmary – Leeds Teaching Hospitals NHS Trust
- Broadmoor Hospital – West London Mental Health NHS Trust/Department of Health

Hospitals identified by the Metropolitan Police in December 2012

- St Catherine's Hospital - Wirral Community NHS Trust
- Saxondale Mental Health Hospital - Nottinghamshire Healthcare NHS Trust
- Rampton Hospital - Nottinghamshire Healthcare NHS Trust
- Portsmouth Royal Hospital - Portsmouth Hospitals NHS Trust
- Dewsbury and District Hospital - Mid Yorkshire Hospitals NHS Trust
- High Royds Psychiatric Hospital - Leeds and York Partnership NHS Foundation Trust
- Wheatfields Hospital - Sue Ryder
- Cardiff Royal Infirmary - Cardiff and Vale University Health Board
- Great Ormond Street - Great Ormond Street Hospital for Children NHS Foundation Trust
- Exeter Hospital - Royal Devon and Exeter NHS Foundation Trust
- Ashworth Hospital - Mersey Care NHS Trust

Hospitals identified by the Metropolitan Police at the end of 2013

- Barnet General Hospital - Barnet and Chase Farm Hospitals NHS Trust
- Booth Hall - Central Manchester University Hospitals NHS Foundation Trust
- De La Pole Hospital - Hull and East Yorkshire Hospitals Trust
- Dryburn Hospital - County Durham and Darlington NHS Foundation Trust
- Hammersmith Hospital - Imperial College Healthcare NHS Trust

- Leavesden Secure Mental Health Hospital - Hertfordshire Partnership University NHS Foundation Trust
- Marsden Hospital - Royal Marsden NHS Foundation Trust
- Maudsley Hospital - South London and Maudsley NHS Foundation Trust
- Odstock Hospital - Salisbury NHS Foundation Trust
- Prestwich Psychiatric Hospital - Greater Manchester West Mental Health NHS Foundation Trust
- Queen Victoria Hospital, East Grinstead - Queen Victoria Hospital NHS Foundation Trust
- Royal Free Hospital - Royal Free London NHS Foundation Trust
- Royal Victoria Infirmary - The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Queen Mary's Hospital - Epsom and St Helier University Hospitals NHS Trust
- Whitby Memorial Hospital - York Teaching Hospital NHS Foundation Trust
- Wythenshawe Hospital - University Hospital of South Manchester NHS Foundation Trust

Allegations received in 2014

- Woodhouse Eaves Children's Convalescent Homes - University Hospitals of Leicester NHS Trust
- Crawley Hospital - Sussex Community NHS Trust

Two hospitals identified by Leeds Teaching Hospitals Trust Savile investigation team

- Springfield Hospital - South West London and St George's Mental Health NHS Trust
- The Royal London Hospital - Barts Health NHS Trust

Appendix J

Discussion event attendees

- Dr Jackie Craissati MBE, clinical director, Oxleas NHS Foundation Trust
- David Derbyshire, director of practice improvement, Action for Children
- Donald Findlater, director of research and development, Lucy Faithfull Foundation
- Dr Peter Green, consultant in child safeguarding, NHS Wandsworth and St George's Hospital
- Shaun Kelly, safeguarding officer, Pearson
- Assistant Chief Constable Ian Pilling, Merseyside Police
- Steve Reeves, director of child safeguarding, Save The Children
- Detective Superintendent Paul Sanford, Norwich Constabulary
- Professor Richard Wortley, director, Jill Dando Institute

Freedom to **speak up**

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

Report

Sir Robert Francis QC

February 2015

Freedom to Speak Up

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

Report

Sir Robert Francis QC

11 February 2015

MAHI - STM - 101 - 016330

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Freedom to **speak up**

Dear Secretary of State

Following the Mid Staffordshire NHS Foundation Trust Public Inquiry I made recommendations designed to make the culture of the NHS patient focused, open and transparent – one in which patients are always put first and their safety and the quality of their treatment are the priority. You accepted almost all the recommendations and significant progress has been made towards their implementation. As a result I believe the NHS has improved its ability to provide better and safer care.

Part of this progress is an increasing recognition of the contribution staff can make to patient care through speaking up. However you identified a continuing problem with regard to the treatment of staff who raise genuine concerns about safety and other matters of public interest, and the handling of those concerns. You asked me to conduct an independent review and to make recommendations for improvement in this area.

I now present my Report to you.

The NHS is blessed with staff who want to do the best for their patients. They want to be able to raise their concerns about things they are worried may be going wrong, free of fear that they may be badly treated when they do so, and confident that effective action will be taken. This can be a difficult and a brave thing to do, even in a well run organisation or department, but will be extremely challenging when raising concerns is not welcomed.

The handling of concerns is not easy for the employers. They find difficulty in distinguishing between concerns which are genuine and those which are not. They are worried about their ability to address the admittedly small number of employees who raise dubious concerns in order to impede justifiable management action. Finding the time and resources to deal sensitively with these issues is challenging, particularly given the other pressures they have to cope with.

A service as important and as safety critical as the NHS can only succeed if it welcomes the contribution staff can make to protecting patients and to the integrity of the service. Valued staff are effective staff. A listening system is a safer system. Organisations which ignore staff concerns, or worse, victimise those who express them are likely to be dangerous places for their patients.

I would have liked to report to you that there was in fact no problem with the treatment of ‘whistleblowers’ and their concerns. Unfortunately this is far from the case. I was not asked to come to judgments about individual cases, but the evidence received by the Review has confirmed to my complete satisfaction that there is a serious issue within the

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NHS. It requires urgent attention if staff are to play their full part in maintaining a safe and effective service for patients.

In fact there was near unanimity among staff, managers, regulators and leaders who assisted the Review that action needs to be taken. The number of people who wrote to the Review who reported victimisation or fear of speaking up has no place in a well-run, humane and patient centred service. In our trust survey, over 30% of those who raised a concern felt unsafe afterwards. Of those who had not raised a concern, 18% expressed a lack of trust in the system as a reason, and 15% blamed fear of victimisation. This is unacceptable. Each time someone is deterred from speaking up, an opportunity to improve patient safety is missed.

The effect of the experiences has in some cases been truly shocking. We heard all too frequently of jobs being lost, but also of serious psychological damage, even to the extent of suicidal depression. In some, sad, cases, it is clear that the toll of continual battles has been to consume lives and cause dedicated people to behave out of character. Just as patients whose complaints are ignored can become mistrustful of all, even those trying to help them, staff who have been badly treated can become isolated, and disadvantaged in their ability to obtain appropriate alternative employment. In short, lives can be ruined by poor handling of staff who have raised concerns.

The consistency in the stories told to us by students and trainees about the detriments they could face was alarming. These were mainly young people at the start of their careers who genuinely believed they should raise issues for the benefit of patients. Of none of them could it be said that they had axes to grind. Their overwhelming sense was one of bemusement that anyone would want to treat them badly for doing the right thing. Yet we heard far too many stories from them of being bullied, and of their assessments suddenly becoming negative.

We know that thousands of reports of incidents and matters of concern are dealt with satisfactorily all the time, but the story from managers and leaders of organisations was just as concerning as that we heard from staff.

There is a marked lack of the skills needed to resolve difficult and sensitive situations that can arise when staff performance is questioned. Too often people resort to formal process and make assumptions that the person who identifies a problem is the problem. Hard pressed managers are often given insufficient resources to ensure that the facts are established objectively and swiftly each time a concern is raised, and instead hunt for someone to blame.

We should not forget either the plight of other staff involved in issues of this sort. Not all concerns raised in good faith are correct. There can be misunderstandings, incomplete information, and reasonable explanations for the unusual. Even where

there is something to be corrected, sensitive handling and insight can often solve the problems raised without prejudicing the welfare of those affected. However, we have seen cases where a culture of blame leads to entrenched positions, breakdown of professional relationships and considerable suffering, utterly disproportionate to the nature of the problem from which this process originated. Staff have responsibilities, too, to raise concerns in a way that is sensitive to the impact on colleagues – and their employers – of what they say and do.

There is a need for a culture in which concerns raised by staff are taken seriously, investigated and addressed by appropriate corrective measures. Above all, behaviour by anyone which is designed to bully staff into silence, or to subject them to retribution for speaking up must not be tolerated. The measures I recommend in this report are largely about doing better what should already be done. They build on the progress made in implementing the culture change started following my earlier report. I set out 20 Principles which I believe should guide the development of a consistent approach to raising concerns throughout the NHS, whilst leaving scope for flexibility for organisations to adapt them to their own circumstances. I have described what appear to me to be the essential features of good practice and have recommended actions to help achieve each of the Principles. I believe implementing these recommendations would result in a great improvement to the present position.

The overarching Principle is that every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern. This is something to which everyone associated with the NHS, from you as Secretary of State, to frontline staff, can and should contribute. We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement. That is the way to ensure that staff can make the valuable contribution they want to offer towards protecting patients and the integrity of the NHS. Most importantly the risks to patients' lives and well-being will be reduced, and confidence in the NHS protected.

I very much hope you will find this Report useful in achieving that end.

Yours sincerely

Sir Robert Francis QC

Executive Summary

Introduction

1 This Review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up. In recent years there have been exposures of substandard, and sometimes unsafe, patient care and treatment. Common to many of them has been a lack of awareness by an organisation's leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did. The 2013 NHS staff survey showed that only 72% of respondents were confident that it is safe to raise a concern. There are disturbing reports of what happens to those who do raise concerns. Yet failure to speak up can cost lives.

2 The aim of the Review was to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. The Review is not the Public Inquiry that some have demanded, and it has not been tasked with investigating or passing judgment on individual cases. Its purpose has been to draw lessons from the experiences of those involved in raising and handling concerns. It has been important to hear these experiences, good and bad, to achieve this.

3 The message from staff who have suffered as a result of raising concerns has been loud and clear. I heard shocking accounts of the way some people have been treated when they have been brave enough to speak up. I witnessed at first hand their distress and the strain on them and, in some cases, their families. I heard about the pressures it can place on other members of a team, on managers, and in some cases the person about whom a concern is raised. Though rare, I was told of suicidal thoughts and even suicide attempts. The genuine pain and distress felt by contributors in having to relive their experiences was every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries. The public owe them a debt of gratitude in the first place for speaking up about their concerns, and secondly for having the courage to contribute to this Review.

4 The experiences shared with us, and the suffering caused by them, have no place in a service which values, as the NHS must, its workforce and the profound contribution they make to patient safety and care. The NHS has a moral obligation to support and encourage staff to speak out.

5 I also heard it suggested that some people raise concerns for dubious motives, such as avoiding legitimate action to address poor performance. It was not within the remit of the Review to pass judgment on whether any of the cases we heard fell into this category. To the extent that this happens, it is highly regrettable, not least because it taints some people's view of whistleblowers and makes it harder for the many NHS staff who raise genuine concerns. Whatever the motive, the patient safety concerns they raise may still be valid and need to be addressed as well the performance issue. It is clear to me that in too many cases this is not done. Suggestions of ulterior purposes have for too long been used as an excuse for avoiding a rigorous examination of safety and other public interest concerns raised by NHS staff.

6 I recognise that cases are not always clear-cut. We heard contradictory accounts of some cases from those with different perspectives. There is nevertheless a remarkable consistency in the pattern of reactions described by staff who told of bad experiences. Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised. Whilst there may be some cases in which issues are fabricated or raised to forestall some form of justifiable action against them, this cannot be true of them all. I have concluded that there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them.

7 There are many reasons why people may feel reluctant to speak up in any industry. For example, they may be concerned they will be seen as disloyal, a 'snitch' or a troublemaker. Two particular factors stood out from the evidence we gathered: fear of the repercussions that speaking up would have for an individual and for their career; and the futility of raising a concern because nothing would be done about it.

8 The NHS is not alone in facing the challenge of how to encourage an open and honest reporting culture. It is however unique in a number of ways. It has a very high public and political profile. It is immensely complex. It is heavily regulated, and whilst the system consists of many theoretically autonomous decision-making units, the NHS as a whole can in effect act as a monopoly when it comes to excluding staff from employment. Further, the political significance of almost everything the system does means that there is often intense pressure to emphasise the positive achievements of the service, sometimes at the expense of admitting its problems.

9 Speaking up is essential in any sector where safety is an issue. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish. There needs to be a more consistent approach across the NHS, and a coordinated drive to create the right culture.

Background: legal and policy context

10 This Review took place in a complex and changing climate. The legal and policy framework surrounding whistleblowing is not easy to understand and has many layers. The detail of the law for the protection of whistleblowers has been amended frequently and recently. There is a range of other reviews, as well as measures and initiatives at both local and national level that will directly or indirectly have an impact on the ease with which NHS workers can speak up. This shows recognition of the issues described in this report, and the need for action to address them. However it is important that these measures are brought together. I have attempted to take account of them in the Principles and Actions, but it will be important that those charged with their implementation place them appropriately in the context.

Legal context

11 In brief, the legislation which theoretically provides protection for whistleblowers is contained in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998, commonly known as PIDA. Where a worker makes a protected disclosure, he/she has a right not to be subjected to any detriment by his employer for making that disclosure.

12 For a number of reasons this legislation is limited in its effectiveness. At best the legislation provides a series of remedies after detriment, including loss of employment, has been suffered. Even these are hard to achieve, and too often by the time a remedy is obtained it is too late to be meaningful.

13 The legislation does nothing to remove the confusion that exists around the term 'whistleblowing', which does not appear in it at all. It was clear from the written contributions and meetings that the term means different things to different people or organisations. It is sometimes taken to imply some sort of escalation: someone 'raises a concern', then 'blows the whistle' when they are not heard, either within the organisation or to an outside body. Yet this is not how the law defines a protected disclosure.

14 The legislation is also limited in its applicability. It applies only to 'workers' as defined by PIDA, so provides no protection against, for example, discrimination in recruitment, and is only now being extended to include student nurses.

Recent changes and initiatives

15 In recent years there has been a range of measures which may encourage, or impose a responsibility on staff to speak up. These include introduction of a new Statutory Duty of Candour,

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the Fit and Proper Person Test and Care Quality Commission's (CQC) new inspection and ratings regime. At both national and local level there have been initiatives and programmes to encourage and support staff to speak up. A range of advice and support is also available to support individuals via helplines or websites. I concluded that it is too early to assess the combined impact of these initiatives, but that they all help to reinforce the message that speaking up is integral to patient safety and care.

Evidence to the Review

16 It was important to me to hear from as many people who had direct experience of raising and receiving concerns as possible. Over 600 individuals and 43 organisations wrote in response to our invitation to contribute and over 19,500 responded to the staff surveys sent out by independent researchers. We met with over 300 people through meetings, workshops and seminars. This included individuals who had raised concerns, student nurses, trainee doctors, and representatives from professional and regulatory bodies, employers, trades unions, lawyers, Black and Minority Ethnic (BME) groups and organisations that represent whistleblowers to ensure that I was able to understand the issues from all the different perspectives. We held four seminars in different parts of the country with a cross section of invited delegates to consider different stages of the process of raising concerns and potential solutions. I also commissioned independent qualitative and quantitative research.

Experience of employees

17 The vast majority of people who took the time to write to the Review reported bad experiences. Many described a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation. Bullying and oppressive behaviour was mentioned frequently, both as a subject for a concern and as a consequence of speaking up. They also spoke of lack of support and lack of confidence in the process.

18 Despite the efforts to improve the climate described in paragraph 15, many of the contributions described cases that are recent or current. This indicates that there is still a real problem. From the evidence it was apparent that there are problems at a number of stages including deterrents to speaking up in the first place, poor handling of concerns that are raised, and vindictive treatment of the person raising the concerns. This can have a devastating impact on the person who spoke up, including loss of employment and personal and family breakdown.

Vulnerable groups

19 It was also clear from the evidence that there are some groups who, for different reasons, are particularly vulnerable including locums and agency staff, students and trainees, BME groups and staff working in primary care.

Experience of employers in receiving and handling public interest concerns

20 The independent research identified two distinct cultures within organisations. Some took a strict procedural approach when concerns are raised; others took a more open minded, less rigid approach which focused on resolving the issue, learning and communicating rather than following procedure. The researchers concluded that the latter were still at a formative stage and that even where there was a willingness to be more flexible, organisations were not entirely sure how to achieve it.

21 Employers who receive public interest disclosures have reported varied experiences. While all accept that many disclosures are made in good faith, they were concerned that some disclosures are made in order to pre-empt or protect the person raising them from performance action or disciplinary processes they face for entirely unrelated issues. The problems employers described included separating safety and other concerns from grievance and disciplinary issues, identifying means of addressing relationship issues, and the need to distinguish between culpability and responsibility.

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Experience of colleagues

22 Concerns about patient safety can have implications for clinical colleagues and managers. An incident or a series of incidents may be attributable to poor performance by an individual clinician or a team. It may be suggested that there is a systemic cause for the concern, such as a staff or equipment shortage for which one or more level of management may be considered responsible. In cultures where blame is an accepted method of explaining a concern, those implicated by a concern are likely to react in a defensive manner. Working relationships with colleagues may suffer, and organisations may default to hierarchical solutions.

The role of regulators and other external bodies

23 Organisations such as regulators and oversight authorities also face issues when approached by workers raising concerns, such as difficulty establishing the facts where reports are made anonymously, or protecting confidentiality. There may also be challenges in distinguishing between appropriately reported cases and referrals which are in retaliation against someone who has raised a concern.

The role of legal advisors

24 When asked for advice by NHS organisations about issues around public interest disclosure, legal advisors have tended to be influenced by an adversarial litigation – and therefore defensive – culture. Lawyers in such circumstances tend to look for potential defences to a claim made under public interest disclosure law, rather than to advise on the positive steps that could be taken to avoid some of the issues described above. Their focus is to pre-empt an Employment Tribunal (ET) claim rather than to assist in the prioritisation of the public interest, or to help resolve a dispute informally by sitting round a table.

Emerging Themes

25 Concerns are raised daily throughout the NHS, and are heard, addressed and resolved. Steps are being taken in some trusts to improve the way in which management responds to concerns. Nevertheless the level of engagement with the Review, the consistency of the stories we heard and the fact that so many of the cases are current or recent convinced me that problems remain and there is an urgent need for system wide action.

26 The evidence presented to this Review is consistent with evidence from other sources. Whilst views may differ about the progress that has been made, there was a remarkable degree of consensus on the need for improvement, the nature of the problems in the system and what a good system would look like. Adopting such a system will benefit not only those who raise concerns, but also patients, management and the wider NHS.

27 From the evidence we drew five overarching themes. These are the need for:

- culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- extending the legal protection.

28 Chapters 5-9 of this report address each of these themes. They set out the Principles which I believe should be followed to bring about the change required, and Actions which follow from each. These are summarised at the end of the Executive Summary. The chapters contain some examples of both good practice that we heard about during the Review. At the end of each section is a summary of what I consider to be good practice in relation to each Principle. This is summarised in Annex A.

Culture

Principle 1 – Culture of safety

Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

29 Culture change is essential, but experience from other sectors where safety is an issue suggests that it takes time and considerable effort by the leadership of an organisation. Boards must devote time and resource to achieving this change. There was support for the concept of a 'just culture' as opposed to a 'no blame' culture. The primary need is to move from a culture which focuses on 'who is to blame?' to one focused on 'has the safety issue been addressed?' and 'what can we learn?'. Without this, senior levels of organisations will remain ignorant of important concerns, some of which give rise to serious safety risks.

30 Progress towards the creation of the right culture should be taken into account by the system regulators in assessing whether an organisation is well-led.

Principle 2 – Culture of raising concerns

Raising concerns should be part of the normal routine business of any well-led NHS organisation.

31 Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their own performance may be the subject of comment, and that this needs to be seen as an opportunity to learn rather than a source of criticism. I appreciate this is not always easy.

32 Policies and procedures for dealing with staff concerns should not distinguish between reporting incidents and making protected disclosures. Our independent research found considerable variation in the quality of policies, and there was agreement that greater standardisation would be helpful given that a proportion of the workforce move between NHS organisations. NHS England, Monitor and the NHS Trust Development Authority (NHS TDA) should produce a standard policy and procedure.

33 To reinforce the concept of raising concerns as a safety issue, responsibility for policy and practice should rest with the executive board member who has responsibility for safety and quality, rather than human resources.

34 Investigation of the concern should be the priority, and any disciplinary action associated with it should not be considered until the facts have been established. This need not delay any performance action that is already underway and unrelated to the concern. It is important that this is well documented to demonstrate that it is not being done in retaliation, to dispel any perception that an individual is being victimised. Poor performance is itself a safety issue, and it is important that it is addressed. The important point here is that managers can show that action taken is justified and is consistent with the way others in the organisation have been treated.

Principle 3 – Culture free from bullying

Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

35 There were more references to bullying in the written contributions than to any other problem. These included staff raising concerns about bullying, or being afraid to do so, bullying of people who had raised concerns and frustration that no-one ever appeared to be held to account for bullying. This is corroborated by the NHS staff survey and by other reports including the

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General Medical Council (GMC) National Training Survey[1] and the Royal College of Nursing (RCN) employee survey[2]. Some individual trusts have also acknowledged the existence of a bullying culture and taken steps to address it.

36 Bullying in the NHS cannot be allowed to continue. Quite apart from the unacceptable impact on victims, bullying is a safety issue if it deters people from speaking up. It also has implications for staff morale and for attendance and retention. We heard many examples of unacceptable behaviour and lack of respect by individuals. This has a significant impact on whether people feel able to speak up, particularly in a hierarchical culture such as the NHS.

37 It is important to take a systems approach when bullying occurs, in line with the concept of a just culture. There needs to be an examination of the causes of bullying behaviour. If it is the result of unacceptable demands or pressures on an individual, they should be addressed first. There is also a need for honest and direct feedback to individuals about the impact of their behaviour, and support provided where this might be more productive than admonition. Failure to modify bullying behaviour should always be a matter for disciplinary action.

38 All leaders and managers in NHS organisations must make it clear that bullying and oppressive behaviour is unacceptable and will not be tolerated. Everyone needs to develop self-awareness about their own behaviour and its effect on others. Everyone in leadership and managerial positions should be given regular training on how to address and how to prevent bullying. Regulators should consider the prevalence of bullying in an organisation as a factor in determining whether it is well-led, and any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

Principle 4 – Culture of visible leadership

All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

39 Visible leadership is essential to the creation of the right culture. Leaders at all levels, but particularly at board level, need to be accessible and to demonstrate through actions as well as words the importance and value they attach to hearing from people at all levels. There is some excellent practice in some trusts, which should be shared and adopted across the NHS.

Principle 5 – Culture of valuing staff

Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

40 Public recognition of the benefits and value of raising concerns sends a clear message that it is safe to speak up, that action will be taken, and that the organisation has the confidence to be transparent and open about things that need to be addressed and wants to hear about them. There was no appetite for financial incentives for individuals, and I do not believe it is either necessary or desirable to offer them.

Principle 6 – Culture of reflective practice

There should be opportunities for all staff to engage in regular reflection of concerns in their work.

41 The Review heard many examples of reflective practice, where issues are explored, systems are analysed and problems or best practice shared. These are invaluable, and should be encouraged throughout the NHS. We also heard that the pressure on the service means that the time available for such practice is being squeezed.

1 *National Training Survey 2014: bullying and undermining*, General Medical Council, November 2014
2 *RCN Employment Survey 2013*, Royal College of Nursing, September 2013

In some cases staff are expected to attend in their own time. I fully recognise the demands and pressures on the system. However these opportunities are essential as a means of sharing information and learning. Just as important, they help to develop a culture of openness and focus on safety not blame, and send a clear signal to staff that this is important.

Handling Cases

42 It was clear in so many of the cases we heard about that if they had been handled well from the outset, a great deal of pain and expense could have been avoided. The more issues can be 'nipped in the bud', the greater the likelihood that there will be a successful outcome for everyone involved. A common factor in many of the cases we heard about was the length of time they took to resolve, if indeed they were ever resolved. Some had gone on so long it was impossible or impracticable to get the full picture. The impact of this on both individuals and organisations was immense.

Principle 7 – Raising and reporting concerns

All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

43 Many concerns are raised every day, and resolved quickly and informally. This should be encouraged wherever possible, provided it is done openly and positively. Where a concern involves a serious issue or incident or where there is disagreement about the seriousness of the concern, there needs to be a more formal mechanism for logging it, processing it and monitoring how it is being handled. This will provide a clear trail for future reference and avoidance of dispute, and also helps to identify trends, common issues and patterns to enhance organisational learning.

44 Any system needs to be as simple and free from bureaucracy as possible. However it needs to provide clarity to the person who has raised a concern about what will happen next and how they will be kept informed of progress. This report sets out what I consider to be the minimum requirements of a system and procedure to ensure that cases are well handled. This was drawn up from the problems that were described in the written contributions and in meetings, and the solutions discussed at the seminars. To ensure it is taken seriously, the Chief Executive Officer (CEO) or a designated board member needs to be involved and should regularly review all concerns that have been logged formally to ensure they are being dealt with appropriately and swiftly.

45 We heard differing views about the desirability of allowing concerns to be raised anonymously, as distinct from in confidence. They can be harder to investigate, and the motive for doing so may be questionable. In an ideal world it would not be necessary to raise concerns anonymously. In the meantime I am persuaded that they have an important role to play and should be treated as formal concerns. I was reassured to find that an anonymous concern sent to several organisations was taken seriously and acted upon.

Principle 8 – Investigations

When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

46 Three clear messages that came from contributors were the importance of establishing the facts, and the importance of doing so quickly, and where necessary independently, and the need to feed back to the individual and share learning more widely. In some other sectors where safety is a critical issue there are teams of independent investigators who move in at once and are quickly able to provide an initial report.

47 Where concerns are raised formally, organisations should arrange for the facts and circumstances to be investigated quickly and with an appropriate level of independence. Where the investigation is done internally, it is essential that those conducting it have the appropriate expertise; that they are genuinely independent; and that they have the training and the time to do so

immediately, and are not trying to fit it in around their normal duties.

48 I am not persuaded that it is necessary to insist that all investigations are undertaken by external investigators. Nor do I consider that it would be appropriate to prescribe timescales for investigating concerns in the NHS, not least because the range of issues and circumstances is so diverse.

49 Feedback to the person who raised the concern is critical. The sense that nothing happens is a major deterrent to speaking up. There are situations where this is not straightforward due to the need to respect the privacy of others involved in the case. However there is almost always some feedback that can be given, and the presumption should be that this is provided unless there are overwhelming reasons for not doing so.

50 Suspensions and special leave should only be used where there is a risk to patient or staff safety, or concern about criminal wrongdoing or tampering with the evidence. If it is necessary to take precautionary measures, efforts should be made to redeploy staff elsewhere on the site or to a non-patient facing role, or to limit their practice. Leaving people on leave or suspension for months on end increases their sense of isolation and the likelihood they will suffer mental health issues which in turn undermine or delay their ability to return to work.

51 There are circumstances where a working environment can become intolerable if someone has, or is believed to have raised a concern which is taken to be critical of colleagues. Ideally the person who spoke up should not be the person who is moved, as this can send a signal that they have done something wrong.

Principle 9 – Mediation and dispute resolution

Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

52 It would be unrealistic to expect a service as complex and pressured as the NHS to run without some professional disagreement or conflict. However poor working relationships can be a risk to patient safety where they impact on communication, morale and willingness to speak up. These need to be addressed, through more proactive management and training in having honest conversations and giving feedback, and through the use of neutral third parties such as a trained mediator.

53 Mediation and dispute resolution techniques can play a role in resolving disputes at a much earlier stage, before positions become entrenched or relationships break down irretrievably. They can be used to rebuild trust within a team after a difficult period. Mediation needs to be done by trained experts and by people who understand the context within which they are operating.

Measures to support good practice

54 Creating the right culture and enabling the effective formal handling of concerns are essential if the ability of NHS staff to raise concerns is to be improved. In addition a number of other measures are needed to support the system to ensure that it works as it should.

Principle 10 – Training

Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

55 For the system to work effectively, there needs to be more training, both for staff in how to raise concerns and for managers in how to receive and handle concerns. Raising concerns, and being

able to accept, with insight and without being defensive, concerns being raised about one's own practice is a fundamental skill that all NHS workers need to have.

56 Training should be provided through face to face sessions which provide insight into others' perspectives: for example how it might feel if an issue is raised which could be interpreted as personal criticism, or how difficult it can be to raise a sensitive issue with someone more senior. Training in multi-disciplinary teams can help to create a shared understanding and common language and to break down silos. More senior members of staff will need additional training in how to handle concerns.

57 Raising concerns and the role of Human Factors[3] should be included in the curriculum of all healthcare professional training programmes. It is important that there is a high level of consistency in the training provided. I therefore invite Health Education England and NHS England, in consultation with stakeholders, to devise a common structure based on the good practice described in this report, to underpin training provided in trusts.

Principle 11 – Support

All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

58 Another recurrent theme from the contributions was the absence of anyone to turn to for support, either before they spoke up, or once they had done so. This added immeasurably to the personal stress they felt. By contrast those who told us that their experience had been good often mentioned that they felt supported throughout.

59 Two things are needed: clarity about to whom concerns can be reported; and clarity about where to go for support. There are various ways this could be provided, and ideally there will be more than one source. Some trusts have nominated a Non-Executive Director (NED) to receive concerns; some allocate a senior person to act as a buddy, or named executive directors, both to receive concerns and to offer advice.

60 Some trusts have established a new role, sometimes known as a 'cultural ambassador' or 'patient safety ombudsman'. Their role is to act as an independent and impartial source of advice to staff, with access to anyone in the organisation, including the CEO, or if necessary outside the organisation. They can ensure that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and issues addressed; and that there are no repercussions for the person who raised it. They can also act as an 'honest broker' to verify that if there were pre-existing performance issues that were already being addressed, these should continue and cannot be portrayed as a consequence of speaking up.

61 I believe such a role can make a huge contribution to developing trust within an organisation and improving the culture and the way cases are handled. I believe there would be merit in having similar roles in all NHS organisations, with a common job title such as Freedom to Speak Up Guardian, so that those who move between organisations know immediately where to go for help. They could also form a network to share good practice and to identify common issues and themes. I strongly encourage all NHS organisations to consider it. I have stopped short of recommending that all must adopt this model, as I believe boards should decide what is appropriate for their organisation. But as a minimum there needs to be someone to whom staff can go, who is recognised as independent and impartial, has the authority to speak to anyone within or outside the trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed, and has dedicated time to perform this role.

62 It was suggested that some may not be comfortable seeking advice from a Freedom to Speak Up Guardian if, for example, they are from a different professional background. There should

3 A definition of Clinical Human Factors is "Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation or human behaviour and abilities, and application of that knowledge in clinical settings." See Clinical Human Factors Group website http://chfg.org/what-is-human-factors

therefore be a range of others to whom people can go for advice and support. This should include at least one executive director, which may be the person responsible for safety and/or the medical director; at least one nominated manager in each department; and one external organisation, such as the Whistleblowing Helpline.

63 Support should also be available in the form of counselling and other psychological support. The evidence seen by the Review indicates that psychological damage is a foreseeable risk of not treating staff correctly when concerns are raised. We heard harrowing accounts from people about anxiety and depression due to the stress and repercussions of raising a concern, and in too many cases counselling appeared to have been promised but never materialised. This is short-sighted as well as uncaring, as it delays the point at which staff are able to return to work, and could conceivably lead to expensive litigation.

Principle 12 – Support to find alternative employment in the NHS

Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

64 A number of people leave their employment, either voluntarily or otherwise, after raising a concern. Some then find it difficult to find another job. The NHS can operate as a monopoly employer in many fields, and a contentious parting of the ways can result in an individual being disadvantaged when applying for a new role, without the full facts of a case being known. This is unfair on individuals, and a waste of valuable skills and resource to the NHS.

65 Where an Employment Tribunal orders reinstatement in a case involving protected disclosures, NHS organisations have a moral responsibility to re-instate the individual if at all possible, if their performance is sound, with appropriate support and development for them and/or for their colleagues to ensure they are re-integrated effectively.

66 Beyond that, there needs to be a support scheme for staff who are having difficulty finding employment and can demonstrate that this is related to having made a protected disclosure, and about whom there are no issues of justifiable and significant concern about their performance. This should be run jointly by NHS England, the NHS TDA and Monitor, and should be supported by all NHS organisations. As a minimum it should provide:

- remedial training or work experience for registered healthcare professionals who have been away from the workplace for long periods of time
- advice and assistance in relation to applications for appropriate employment in the NHS
- the development of a 'pool' of employers prepared to offer trial employment
- guidance to employers to encourage them to consider a history of having raised concerns as a positive characteristic in a potential employee.

Principle 13 – Transparency

All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

67 Lack of transparency and openness creates suspicion and mistrust. It also means that opportunities to share learning and improve patient safety may be lost. Conversely transparency about incidents and concerns, and how the trust has responded to them, sends an important signal to staff that the board welcomes and values them, and provides an opportunity to demonstrate how they focus on finding solutions and taking action, not on apportioning blame.

68 All NHS organisations should publish in their Quality Accounts quantitative and qualitative data about formally reported concerns. This could then be used by the National Learning and Reporting System to identify safety issues that are common across the NHS, and to spread learning and best practice. This requires the NHS system regulators to adopt a common approach to data about concerns, with a shared understanding of what good looks like so that there is no disincentive to trusts to be transparent and open.

69 My attention was also drawn to the continued use of settlement agreements and to the confidentiality clauses they contain. Any confidentiality clauses which prevent a signatory from making a protected disclosure are void. I did not see any recent agreements which breached this. There were some however which contained restrictions that seemed unnecessarily draconian, and I can appreciate how individuals might think they were 'gagged'. This is a hindrance to transparency. Greater care needs to be taken in the drafting of confidentiality clauses, which should only be included if they are genuinely in the public interest. All settlement agreements should be available for inspection by the CQC.

Principle 14 – Accountability

Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them**
- **the victimisation of workers for making public interest disclosures**
- **raising false concerns in bad faith or for personal benefit**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns**
- **inappropriate use of confidentiality clauses.**

70 Everyone should be held accountable for their behaviour and practice when raising, receiving and handling concerns. This applies to those raising concerns as well as to their leaders and managers. Absence of accountability puts people off speaking up, and can inhibit a person's ability to move on. Seeing a manager who has been responsible for bullying or victimisation move to a new post or even be promoted sends the wrong signal to staff and offends people's innate sense of fairness.

71 It is the responsibility of boards to ensure that there is no victimisation of or retaliation against whistleblowers, and they should be held to account for it. This will require them to maintain constant vigilance, and effective systems to enable them to keep track of what is happening within an organisation where so many people are under pressure to deliver a service. System regulators should look for evidence that this is being taken seriously. I was encouraged to hear optimism about the impact of the CQC's new inspection regime.

72 I do not believe that it would be appropriate to introduce regulation of managers at present. The Fit and Proper Person test has only just been introduced and it should be given time to bed down, and its impact to be assessed.

73 Individuals are also responsible for their own behaviour, and should be prepared to be held to account for it. Everyone who raises concerns must take responsibility for the way in which those concerns are expressed, and show willingness to accept the good faith of those who try to respond reasonably even if the conclusion is not what they would wish. It equally applies to anyone, however senior, who fails to show respect to their colleagues or is unacceptably rude. Such behaviour should not be tolerated, and those who persist with it should be held to account.

Principle 15 – External review

There should be an Independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:

- **review the handling of concerns raised by NHS workers, and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice**
- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect**
- **act as a support for Freedom to Speak Up Guardians**
- **provide national leadership on issues relating to raising concerns by NHS workers**

- **offer guidance on good practice about handling concerns**
- **publish reports on the activities of this office.**

74 I considered whether there is a case for establishing an independent body with powers to review staff concerns. I concluded that it would be wrong to take responsibility for dealing with concerns away from trusts, and would be more likely to lead to delays and additional layers of bureaucracy.

75 I also gave serious thought to the need for a new body to carry out an external review of the way individual cases have been handled and whether detriment occurred. There is a gap in the system of oversight in this area. The CQC can take account of how an organisation handles cases in its assessment of how well it is led. All the systems regulators who are prescribed persons can take action to investigate the issues raised in any protected disclosure made directly to them. But these would not normally include reviewing the way in which the organisation managed their investigation, nor the way in which the individual who raised the concern was subsequently treated. The only route available to an individual who feels he has been subject to detriment for making protected disclosure is to take a case to an Employment Tribunal. However, most do not want to take legal action: all they want is to be assured that patients are safe and to get on with their jobs.

76 Rather than establish yet another new body, which would require legislation as well as new funding, I propose that an Independent National Officer (INO) should be jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England, to operate under the combined aegis of these bodies. The INO would be authorised by these bodies to:

- review the handling of concerns raised by NHS workers where there is reason to believe that there has been failure to follow good practice, particularly failing to address dangers to patient safety or causing injustice to staff
- where this has occurred, to advise the relevant NHS organisation to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it make a direction requiring such action
- offer guidance on good practice
- act as a support for Freedom to Speak Up Guardians
- publish reports on common themes, developments and progress towards the creation of a safe and open culture in the NHS.

77 I want to emphasise I am not proposing an office to take over the investigation of concerns, nor is this a means by which a whistleblower can circumvent existing authorised processes for raising and addressing concerns. It is also not intended to replace existing legal remedies. I do not suggest that the INO should review, still less investigate historic cases.

78 The INO will have discretion to consider how an existing case is being or has been handled, and to advise an organisation on any actions they should take to deal with the issues raised. The officer would need to operate in a timely, non-bureaucratic way. He/she would not take on the investigation of cases themselves, but would challenge or invite others to look again at cases and would need sufficient authority to ensure that any recommendations made were taken seriously and acted upon. The office should be more nimble and less bound by legalistic process than a statutory body, with wide discretion to decide whether it is appropriate to get involved in a particular case. In essence the INO would fulfil, at a national level, a role similar to that played by Freedom to Speak Up Guardians locally and provide national leadership for these issues. The INO should not be expected to review historic issues.

Principle 16 – Coordinated Regulatory Action

There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

79 The review highlighted the lack of any coordination between the various regulators in their approach to whistleblowing. I believe there is scope

for the systems regulators to play a bigger role. In particular I think they should pay more attention to the record of an NHS organisation in respect of how it handles concerns, and take regulatory action where that record is poor. I have suggested that all three should work together, with the Department of Health, to define their roles and agree procedures to ensure that NHS workers are adequately protected.

80 Professional regulators could also do more. The GMC has set up an independent review, chaired by Sir Anthony Hooper, to consider how it treats doctors who raise concerns, and how they might best be supported. Its findings may be relevant to other regulators. It is important that professional regulators are aware of the context in which a referral for investigation of a medical professional is made, to ascertain whether there is any risk that it is a retaliatory referral. I am not suggesting that there should be no investigation because someone has been a whistleblower: there may be a perfectly good justification for doing so. But the regulators need to assure themselves that the referral is fair. I would also urge the professional regulators to consider what they can do to speed up their investigations into fitness to practise.

Principle 17 – Recognition of organisations

CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

81 Organisations which encourage an open and just culture should be recognised and celebrated, for example through a national award scheme, in their CQC assessment or possibly some financial incentive.

Measures for vulnerable groups

82 During the course of the Review it became clear that there are some groups who are particularly vulnerable when they raise concerns.

Locums, agency and bank staff

83 Non-permanent staff are in a more vulnerable position not only because of the temporary nature of their roles, but also because they are not fully integrated members of a team, may miss out on induction explaining how concerns should be raised in this organisation, and lack support. Yet they may bring objectivity and good practice from other organisations which should be welcomed. They should have access to all the same support and procedures as permanent members of staff, and should be encouraged to share their insights.

Principle 18 – Students and trainees

All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

84 Student nurses, other healthcare professional students, and trainees can help to spread good practice because they move around frequently. The group of student nurses I met told me that the need to pass each placement can constrain their ability to speak up: there were disturbing, but consistent accounts of students with previously good records who suddenly found themselves criticised, if not failed, after they raised a concern. We also heard of students being sent to placements despite reports by previous students about bullying behaviour, variable support by universities and petty victimisation (being given all the worst jobs) after raising a concern. The fear of referral for fitness to practise appears to be a further deterrent.

85 All the guidance and Principles that I have proposed for NHS staff should be available to support students and trainees working towards a career in healthcare. There should be additional protection for students. All training establishments should comply with the good practice in this report in relation to:

- including the importance of, and process for raising concerns in the curriculum
- the appointment of an independent person to advise and monitor the well-being of students

who raise concerns
- ensuring practical and emotional support is provided through any investigation process
- monitoring the progress of students who raise concerns, to ensure there is no sudden and unexplained dip in their performance assessments.

86 In addition, the education and training organisations and professional regulators should work more closely when assessing the suitability of placements. Where action is repeatedly not taken in respect of poor placements, the regulator should consider removing its validation of the course.

Staff from black and minority ethnic (BME) background

87 The experiences of BME staff were broadly similar to those of other staff, but without doubt they can feel even more vulnerable when raising concerns. This was partly because the culture can sometimes leave minority groups feeling excluded, and cultural misunderstandings may exacerbate difficulties. This sense of vulnerability appears to be supported by the evidence of our independent research. There is also a perception that BME staff are more likely to be referred to professional regulators if they raise concerns, more likely to receive harsher sanctions, and more likely to experience disproportionate detriment in response to speaking up.

88 Boards need to be aware that this is an issue, and should consider whether they need to take action over and above what is set out in this report to support and protect BME staff who raise concerns in their organisation.

Principle 19 – Primary Care

All principles in this report should apply with necessary adaptation in primary care.

89 It was surprisingly hard to get a clear understanding of the options open to staff who work in primary care. Little, if any, thought seems to have been given to it since the Health and Social Care Act 2012 , which abolished primary care trusts (PCTs).

90 The options would seem to be NHS England or clinical commissioning groups (CCGs), but neither are prescribed persons to whom protected disclosures can be made. Yet it seems more likely that somebody working in a very small organisation will want or need to raise a concern with, or seek advice and support from someone outside their practice particularly if their concern is about one of the senior figures.

91 I consider it essential that the support recommended in this report should be available to NHS staff who work in primary care. We heard about examples of good practice, where trainees were given induction, briefed on the policy, and felt supported by their training scheme programme director, although some trainees waited until they had completed their placement before speaking up. But it was hard to identify any source of support for other members of staff, particularly non-clinical staff.

92 Consideration should be given to how this can be provided. Federations of GP practices may be able to appoint a Freedom to Speak Up Guardian; others may be able to sign up the services of their local NHS trust's Guardian, as happens already in at least one area. NHS England should work with all commissioned primary care services to clarify policies and procedures for staff in line with the Principles in this report, which specify where employees can go for advice and support, and to register a concern.

Extending the legal protection

Principle 20 – Legal Protection should be enhanced

93 Although I do not consider the legal protection is adequate, I firmly believe it is the priority, and more effective, to address the culture and to improve the way concerns are handled so that it is not necessary to seek redress. That has been the main focus of this Review and the report.

94 There are however two steps which should be taken. Some NHS bodies which are not currently prescribed persons to whom disclosures could be

made, should be added to the list. These include NHS England, CCGs and Local Education and Training Boards. Secondly I welcome the intention to extend the scope of the legislation to include student nurses and student midwives. This should go further to include other students working towards a career in healthcare.

95 The legislation applies to all employers, not only those in the NHS, so it would not be appropriate to make recommendations for amendment which might impact on other sectors in ways that I am not aware of. However I am particularly concerned by one aspect of the legislation, which is that it does nothing to protect people who are seeking employment from discrimination on the grounds that they are known to be a whistleblower. This is an important omission which should be reviewed, at least in respect of the NHS. I invite the Government to review the legislation to extend protection to include discrimination by employers in the NHS, if not more widely, either under the Employment Rights Act 1996 or under the Equality Act 2010.

Conclusion

96 The Review confirmed that although many cases are handled well, too many are not. This has a disproportionate impact on others who are deterred from speaking up by the fear of adverse consequences or the belief that nothing will be done. It puts patients at risk.

97 I believe that the Principles and Actions in this report should together make it safe for people to speak up, and provide redress if injustice does occur. The creation of Freedom to Speak Up Guardians and an Independent National Officer in particular are key components of this, to provide support and ensure the patient safety issue is always addressed.

98 It is also important that all who raise concerns, and all who respond to them behave with empathy and understanding of others, focusing together on patient safety and the public interest.

99 I am grateful to all who have shared their experience. It has helped to shape my conclusions and has made a significant contribution to ensuring that others will have a better experience in future. I appreciate that, given my remit, some people may be disappointed that their own issues have not been addressed. Some are now so complex that I doubt that even a public inquiry would be able to resolve them.

100 I hope that genuine concerns will be investigated objectively, learning shared, and those who raise them feel supported and valued, while genuine issues about an individual's performance or conduct are dealt with separately and fairly. Anyone responsible for unacceptable breaches of the responsibilities identified in this report should be held to account, but with understanding of the pressures on them.

101 This will make the NHS a better place to work and a safer place for patients.

102 There is a great deal that can be done by well-led organisations and regulators to bring to life the Principles in this report. It will be for the Secretary of State for Health to ensure that the momentum is maintained throughout the whole of the NHS.

Recommendation 1

All organisations which provide NHS healthcare and regulators should implement the principles and actions set out below, in line with the good practice described in this report[4].

Recommendation 2

The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and to report to Parliament.

4 Principles and actions are summarised at the end of this section and the good practice is summarised at Annex A

Recommendations, Principles and Actions

Recommendations

Recommendation 1

All organisations which provide NHS healthcare[5] and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.

Recommendation 2

The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

Principles and Actions

Culture Change

Principle 1

Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.
Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.

Principle 2

Culture of raising concerns: Raising concerns should be part of the normal routine business of any well led NHS organisation.

Action 2.1: Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.
Action 2.2: NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.

Principle 3

Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

Action 3.1: Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.
Action 3.2: Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.
Action 3.3: Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

Principle 4

Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

Action 4.1: Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.

5 Referred to in these principles as 'NHS organisations' – see glossary

Principle 5

Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

Action 5.1: Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.

Principle 6

Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.

Action 6.1: All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.

Better Handling of Cases

Principle 7

Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Action 7.1: Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.
Action 7.2: All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.

Principle 8

Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

Action 8.1: All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.

Principle 9

Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

Action 9.1: All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to:

- address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern
- repair trust and build constructive relationships.

Measures to support good practice

Principle 10

Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

Action 10.1: Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.

Principle 11

Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

Action 11.1: The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity
b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board
c) at least one nominated executive director to receive and handle concerns
d) at least one nominated manager in each department to receive reports of concerns
e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.

Action 11.2: All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.
Action 11.3: NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.

Principle 12

Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

Action 12.1: NHS England, the NHS Trust Development Authority and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as a result of having made protected disclosures.
Action 12.1: All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.

Principle 13

Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

Action 13.1: All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.
Action 13.2: All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.
Action 13.3:

a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.
b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.
c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.
d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.

Principle 14

Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them**
- **the victimisation of workers for making public interest disclosures**
- **raising false concerns in bad faith or for personal benefit**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns**
- **inappropriate use of confidentiality clauses.**

Action 14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.
Action 14.2: Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.
Action 14.3: All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.

Principle 15

External Review: There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:

- **review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is cause for believing that this has not been in accordance with good practice**
- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect**
- **act as a support for Freedom to Speak Up Guardians**
- **provide national leadership on issues relating to raising concerns by NHS workers**
- **offer guidance on good practice about handling concerns**
- **publish reports on the activities of this office.**

Action 15.1: CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State, as to how it might carry out these functions in respect of ongoing and future concerns.

Principle 16

Coordinated Regulatory Action: There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

Action 16.1: CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.
Action 16.2: Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.

Principle 17

Recognition of organisations: CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

Action 17.1: CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.

Particular measures for vulnerable groups

Principle 18

Students and Trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

Action 18.1: Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the principles and good practice in this report.
Action 18.2: All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns.

Principle 19

Primary Care: All principles in this report should apply with necessary adaptations in primary care.

Action 19.1: NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.
Action 19.2: NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.
Action 19.3: In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.

Enhancing the legal protection

Principle 20

Legal protection should be enhanced

Action 20.1: The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.

Action 20.2: The list of persons prescribed under the Employment Rights Act 1996 should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentry and Health Services Ombudsman.

Action 20.3: The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.

Note: Annex B to this report contains a list of actions showing the organisations responsible for implementing each one.

1

Introduction

1 Introduction

> *"I believe that the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance or health of another could make a greater potential contribution to patient safety than any other single factor"*
>
> *Dame Janet Smith*[6]

1.1 It is now over ten years since Dame Janet Smith wrote to the then Secretary of State for Health alongside her fifth report on the Shipman Inquiry. Her statement rings as true now as it did then. Staff who raise concerns about any issues of patient safety can and do save lives.

1.2 Since her report, and more recently since the reports into the events at Mid Staffordshire[7,8], a number of policies, processes and initiatives have been put in place to try to foster a more open and honest culture in the NHS. However, problems remain. These problems are not confined to the NHS. In recent months there have been many high profile stories about whistleblowers and scandals that might have been averted had people spoken up sooner, or been listened to, in a range of sectors, ranging from adult social care and child protection to international football. Speaking up is essential in almost all forms of collective enterprise, whether commercial or in the public sector. It is particularly important where safety is critical.

1.3 Whilst the NHS is not alone in facing the challenge of how to encourage an open and honest reporting culture, there are some respects in which it is unique:

- the NHS is probably the most valued institution in this country and therefore its success is important to us all. Its achievements in overcoming the challenges posed by illness, disability and disease are evidenced by countless stories of the inspirational work the NHS does every day
- it is a highly complex, and heavily regulated collection of organisations, constantly in the public eye and on the political agenda
- there is great public and political pressure on the service to produce success for every patient all of the time and to regard a failure to do so as a matter for which individuals must be held to account
- almost all of us will have experience of it, either directly or indirectly, and at a time when we are likely to be at our most vulnerable
- for every successful advance in medicine, there is likely to be an increase in the demands on the service. The task of innovation, improvement and increased delivery is never complete and never stabilised
- its culture has, traditionally, been very hierarchical in which reports of 'success' are in constant demand and reports of 'failure' are unwelcome.

1.4 Speaking up is especially important in the NHS because failure to foster a culture in which is it safe to raise concerns can cost lives. Everyone working in the NHS is in a position to identify unsafe care, to spot where things could be improved or if errors have been made. The leadership of an organisation cannot act if it is not told about things that are going wrong, inappropriate behaviour or even honest fears that something does not feel right.

1.5 When an NHS worker speaks up, they are making a vital contribution to the quality and safety of patient care. This is true not just of doctors, nurses, and other qualified healthcare professionals, but of all NHS workers regardless of position. A cleaner employed by a contractor is just as likely to witness an unsafe situation as a hospital's chief executive. A student nurse may offer a fresh insight lost to a tired senior colleague.

1.6 Almost as important, NHS workers are all in a position to contribute to protecting the integrity of the service. Every time money or equipment are wasted or stolen the resources to treat patients are reduced. Every time a patient or a colleague is deceived, intentionally or otherwise, public confidence in the service can be threatened.

6 *Fifth Report of the Shipman Inquiry – Safeguarding Patients: Lessons from the Past – Proposals for the Future, Dame Janet Smith*, 9 December 2004
7 *The Mid Staffordshire NHS Foundation Trust Inquiry*, Robert Francis QC, 24 February 2010
8 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013

1.7 The interdependence of the many different elements of the NHS system adds to the complexity of this issue. Each part of the system has a continuing need for information about what is or may be going wrong and indeed on what is going well. The complexity is a potential barrier to important information being received and acted upon in the right places in the system. The risk of this can be reduced to some extent by carefully thought through and operated systems of cooperation, information sharing, and coordinated action. However, there is a risk of organisational boundaries being used as an excuse to ignore or deflect important information. The requirements of confidentiality, sometimes more imagined than real, can be exploited to prevent communication.

1.8 While the system consists of many theoretically autonomous decision-making units, the NHS as a whole can in effect act as a monopoly when it comes to excluding staff from employment. In addition to formal mechanisms, such as the performers list regulatory structure for general medical practitioners, there are inevitably informal networks which will share information on a non-attributable basis. A result can be that the exclusion of a staff member, particularly a doctor or nurse, from one employment will mean that they cannot find work elsewhere.

1.9 Additionally, although the system is intended to be increasingly independent of Government, the political significance of almost everything the system does means there is often intense pressure to emphasise the positive achievements of the service, sometimes at the expense of recognising its problems. Without a shared culture of openness and transparency in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish.

Background to the Review

1.10 This Review was set up in response to concerns about the reporting culture in the NHS, and the way NHS organisations deal with concerns and with the staff who raise them. Over recent years, a number of organisations have been found to provide substandard, and sometimes unsafe, care and treatment to patients. The Mid Staffordshire NHS Foundation Trust scandal is probably the most well-known, but there have been others identified by the Care Quality Commission (CQC), the Keogh Review[9] and the media. There have also been media reports about the way people who raise concerns have been treated. In this Report we have shared examples of their experiences, some of which are shocking.

1.11 Efforts are undoubtedly being made to improve patient safety in the wake of the Mid Staffordshire Inquiry and other reports. However, there is also evidence to suggest that a key source of information, the people who work at the front line, is still not being sufficiently valued. In the most recent NHS staff survey[10], only 64% of NHS workers felt confident that their organisation would address their concern. Not only do staff feel they are ignored, a significant number fear there will be consequences for them if they do speak up. 72% of people who responded said they would feel safe raising a concern. 10% of staff (almost 17,000 out of 168,000 respondents) said they felt unsafe, and a further 18% (30,000) said they were unsure. This is too many.

Terms of reference[11]

1.12 The aim of this Review was to provide advice and recommendations to ensure that staff working in, or providing services to, the NHS in England feel that it is safe to raise honestly held concerns of any sort in the interest of patient safety. In particular, I was asked to consider measures to ensure that staff:

9 *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, Professor Sir Bruce Keogh KBE, 16 July 2013
10 *2013 NHS Staff Survey*, Picker Institute Europe, 2013
11 The full terms of reference can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322798/terms_reference.pdf

- feel able to raise concerns, confident that they will be listened to, and that appropriate action will be taken, if they make disclosures about quality of care, malpractice or wrongdoing at work
- will not suffer detriment as a result of raising concerns or making a disclosure
- have access to appropriate remedies if they are mistreated as a result of raising concerns
- are reassured that those mistreating them will be held to account.

1.13 I was also asked to consider what further action is necessary to support those NHS workers who are brave enough to speak up, in particular:

- the role of the Employment Rights Act 1996[12] ('the 1996 Act')
- the interface between procedures for raising concerns and making disclosures in the public interest
- the merits and practicalities of independent mechanisms to resolve disputes
- options to support people who have raised concerns to return to employment in the NHS, where Employment Tribunals or courts have found in their favour.

1.14 It is important to be clear that this was not a public inquiry. I was not asked to investigate individual cases or pass judgment on historic cases, but to use the experience of the past to formulate recommendations for the future. A number of individuals did share their cases with me. I know that some are disappointed that I have not been able to get personally involved in their case or help to resolve their concerns. However, I hope that they seek some comfort from the fact that I have taken their experiences into account in producing this report, and that my conclusions and recommendations are very much informed by the assistance they have given the Review.

1.15 Even though I have not passed judgment on individual cases, I am confident that there is a pattern of reaction to the raising of concerns in the NHS which inhibits rather than encourages speaking up, turns a blind eye to the real issues that are raised, and often turns on the person who raises them rather than addresses what is important for patients and the public.

The scope

1.16 The scope includes all organisations and individuals who provide NHS services including foundation trusts, private providers of NHS services and mental healthcare services. It also covers providers of NHS healthcare services in the community and general practice. The Review covers the NHS in England but not in the devolved administrations. The remit did not cover the provision of privately funded medical care or any form of social care. Nonetheless the lessons to be learned may well be of assistance in all these areas.

1.17 The Review has looked at 'protected disclosures' within the meaning of the 1996 Act[13], but I have not limited the Review to any strict statutory definition. It is likely that any disclosure of information which tends to show a concern about the quality of care, malpractice or wrongdoing at work would come within one or more of the statutory categories set out in 2.2. Although in some circumstances a public disclosure of information, for instance to a newspaper, is protected, the conditions for obtaining statutory protection are different. I heard virtually no suggestion that the freedom for workers to disclose their concerns in public should be increased, and therefore I have limited my consideration to internal disclosures, and those made to regulators and other prescribed persons.

12 As amended by the Public Interest Disclosure Act 1998, commonly referred to as 'PIDA' and subsequent legislation
13 The Public Interest Disclosure Act 1998 operates by amending the Employment Rights Act 1996. As such the operative legislation for the purposes of considering protected disclosures is the 1996 Act. Nonetheless, and although legally imprecise, it is commonplace for people to refer to 'PIDA' when discussing protected disclosures

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1.18 The protection of patients from unsafe treatment should be at the heart of any system encouraging staff to raise their concerns. The focus of this Report is on what is required to bring that about. Therefore wherever there is a reference to 'raising concerns', 'speaking up' or 'whistleblowing' it should be considered to refer to the raising of a concern relevant to safety or the integrity of the system. I include in this concerns about oppressive behaviour or bullying and dysfunctional working relationships, which I consider to be safety issues.

Approach and methodology

1.19 As required by the terms of reference the approach of the Review was to listen to the views and experiences of individuals and stakeholders with an interest in this area to identify what needs to be improved. The Review looked to:

- understand the issues from a range of different perspectives
- identify the problems individuals and organisations face
- seek views on possible solutions in order to identify measures that would help to promote an open and honest reporting culture.

This involved close engagement with NHS workers who wanted to share their experiences of raising concerns, as well as employers, system and professional regulators and representative bodies.

1.20 The Review gathered information in a number of ways:

- a call for written contributions and a thematic review of responses
- meetings with a broad range of individuals and stakeholder groups
- seminars to discuss emerging themes and possible solutions
- qualitative research:
  - a desk analysis of 21 whistleblowing policies
  - an interview-based analysis of how policies are implemented in the NHS.
- quantitative research – surveys of staff, employers and regulators
- desk analysis and meetings about whistleblowing in other sectors
- desk analysis of whistleblowing in other countries.

1.21 The research and seminar reports are available at www.freedomtospeakup.org.uk. A summary of findings is at chapter 3 and key themes are at chapter 4. Further evidence from other sources is described in later chapters.

Previous reviews

1.22 In recent years there have been a number of reviews that have considered whistleblowing or related issues in the NHS and other sectors. These include the reports of the Mid Staffordshire NHS Foundation Trust inquiries[14,15], the National Audit Office's (NAO) reports on whistleblowing[16], Public Concern at Work's Whistleblowing Commission[17] and the Department of Business, Innovation and Skills' response to its whistleblowing framework call to evidence[18].

1.23 Other relevant reviews include: Don Berwick's report on patient safety[19], the report by the Rt Hon Ann Clwyd MP and Professor Tricia Hart on NHS complaints[20], the report of Sir David Dalton and Professor Sir Norman Williams on duty of candour[21] and the Dalton Review[22] to explore ways to address the challenges faced by providers of NHS care.

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14 *The Mid Staffordshire NHS Foundation Trust Inquiry*, Robert Francis QC, 24 February 2010
15 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013
16 *Making a Whistleblowing Policy Work*, National Audit Office, March 2014 and Government Whistleblowing Policies, National Audit Office, January 2014
17 *The Whistleblowing Commission, Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK*, Public Concern at Work, November 2013
18 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014
19 *A Promise to Learn – A commitment to Act, Improving the Safety of Patients in England*, National Advisory Group on the Safety of Patients in England, August 2013
20 *A Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture*, Right Honourable Ann Clwyd MP and Professor Tricia Hart, October 2013
21 *Building a Culture of Candour – A review of the threshold for the duty of candour and of the incentives for care organisations to be candid*, Sir David Dalton and Professor Norman Williams, March 2014
22 *Examining new options and opportunities for providers of NHS Care*, Sir David Dalton, December 2014

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1.24 Each of these reports considered measures that contribute to an open and honest culture, including organisational transparency and leadership. The themes identified in these reports that are relevant to whistleblowing and the implications for patient safety appear broadly consistent with the evidence submitted to this Review. That it is still a problem despite so much attention underlines just how intractable it has been. However, there are encouraging signs that there is a genuine will to make progress, and a growing awareness of the contribution staff can make when encouraged to speak up. For example, the Dalton Review made clear that leaders should listen and respond to the insights of staff and recognise that ideas for improvement are generally found within their own organisations.

Concurrent reviews

1.25 There have also been a number of reviews taking place in parallel to this Review whose findings and recommendations are likely to be relevant to the issues considered in this report. These include:

- the Assurance Report by Kate Lampard CBE on the Jimmy Savile Investigations
- Lord Rose's review of NHS leadership
- the General Medical Council's (GMC) review of whistleblowing by Sir Anthony Hooper
- the Health Select Committee's Inquiry on complaints and raising concerns.[23]

Structure of report

1.26 This report sets out the findings of the Freedom to Speak Up Review and the Principles and Actions that I believe are necessary to create an open and honest culture in the NHS and to ensure those who do speak up feel valued and supported. It includes chapters on:

- an overview of the legal and policy context including the roles of various organisations and recent initiatives
- a summary of the evidence from contributors including employees, employers, professional bodies, regulators, trade unions and others
- key themes from the evidence and Principles and Actions needed to bring about change:
  - culture change
  - improved handling of cases
  - measures to support good practice
  - particular measures for vulnerable groups
  - extending the legal protection.

Anonymisation

1.27 The overwhelming majority of contributions to the Review were made in confidence. To protect the identity of individuals, the case studies in this report have been anonymised and in some cases the gender changed so that they do not identify individual cases or organisations. It would not be in the public interest to do otherwise. Individuals, some of whom have had harrowing experiences, would have been much less likely to assist the Review without an assurance of complete confidentiality. It would be a betrayal of that trust for that assurance to be broken now.

1.28 Quotes have also been anonymised. Typographical errors have been corrected but the meaning has not been changed.

Glossary

1.29 There are some terms I have used in this report that are open to interpretation such as 'staff' or 'NHS organisations'. There is a glossary at Annex E to explain the context I am using for such terms in this report. It also includes descriptions of other terms that may be less well understood by the general reader.

The Review team

1.30 I was asked by the Secretary of State for Health to chair the Review and I appointed the following to advise on issues relating to specific areas and professions within the NHS:

- Professor Katherine Fenton OBE, Nursing Advisor

23 *4th Report - Complaints and Raising Concerns*, Health Select Committee 2015 (published after completion of this report)

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- Dr Peter Homa CBE, NHS Chief Executive Advisor
- Professor Sir Norman Williams, Medical Advisor.

1.31 Advice was also sought from Helené Donnelly OBE, a nurse who raised concerns at Mid Staffordshire NHS Foundation Trust and is now Cultural Ambassador at Staffordshire and Stoke on Trent Partnership NHS Trust.

1.32 The Review was supported by a secretariat staffed by civil servants, appointed for their relevant skills and experience. The secretariat was led by Joanna Donaldson, former HR Director at the Department for Business, Innovation and Skills. The secretariat worked exclusively on the Review. A secure office was set up, supported by non-government IT systems, to ensure that the Review remained totally independent of the Department of Health.

Acknowledgments

1.33 This Review would not have been possible without the commitment and hard work of the secretariat. Every member of the team has demonstrated integrity, independence, and rigour in their approach to the task set for us. Their support for me has been outstanding, and their sensitivity and empathy for the sometimes very distressed people who have assisted the Review has been remarkable. I also owe a great debt to my advisors who have devoted a great deal of time to helping me in the formulation of my conclusions and recommendations. Their wisdom has been invaluable.

1.34 Above all, it has been a privilege to meet, and read the contributions of, so many people who work or have worked in the NHS and want the best for its patients and the public. Many have offered their help in spite of having suffered great hardship, and being obliged to relive experiences they would probably prefer to forget. It is also right to place on record that the Review has been substantially assisted by many NHS leaders and managers who have not only recognised the problems identified in this report, but have had the courage and conviction to do something about them.

1.35 This report is the result of the combined contributions of so many people, but the responsibility for its contents remains mine and mine alone.

2

Overview of the legal and policy context

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2.1 Introduction

2.1.1 In order to set the scene and to illustrate the complexity of the issue, this chapter describes the legal and policy context. It covers:

- the legal framework in relation to whistleblowing in England (see 2.2)
- individual and organisational responsibilities as they relate to raising concerns (see 2.3)
- roles and responsibilities of regulators and others to investigate concerns, support whistleblowers and to assess the culture of an organisation (see 2.4)
- national initiatives in raising concerns (see 2.5)
- guidance and advice for staff raising concerns (see 2.6).

2.1.3 It is not intended to be a comprehensive picture but gives a flavour of the structure within which raising concerns and whistleblowing sits.

2.2 The legal framework in relation to whistleblowing

2.2.1 This section covers:

- Employment Rights Act 1996
- Confidentiality clauses
- Equality Act 2010.

As referred to in 2.1, it provides an indication of the framework that is in place rather than a comprehensive guide.

Employment Rights Act 1996

2.2.2 Current legislation on whistleblowing in England is contained in the Employment Rights Act 1996 ('the 1996 Act' or ERA). The protection is set out in the 1996 Act as amended and is popularly known as the Public Interest Disclosure Act 1998 or 'PIDA' after the legislation which inserted the whistleblowing provisions into the 1996 Act. Where a worker, as defined in section 43K of the 1996 Act makes a protected disclosure he/she has a right[24] not to be subjected to any detriment by his/her employer, a fellow employee or an agent of the employer for making that protected disclosure.

2.2.3 The provisions in the 1996 Act relating to the definition of 'worker' have been extended to include categories of worker who might not otherwise fall within the definition of employee or worker under the 1996 Act. Examples include self-employed individuals such as GPs, community pharmacists, dentists and ophthalmic practitioners. Subject to legislation, student nurses and student midwives will shortly be included in the wider definition of worker.

2.2.4 A disclosure of information qualifies to be considered as a protected disclosure if it is made by a worker who reasonably believes it is in the public interest and if it tends to show one or more of the following[25]:

- that a criminal offence has been, is being, or is likely to be, committed
- that a person has failed, is failing, or is likely to fail, to comply with any legal obligation to which he/she is subject

24 Employment Rights Act 1996, section 47B
25 Employment Rights Act 1996, section 43B

- that a miscarriage of justice has occurred, or is likely to occur
- that the health or safety of any individual has been, is being, or is likely to be endangered
- that the environment has been, is being, or is likely to be damaged
- that information tending to show any of the above matters is being or is likely to be deliberately concealed.

2.2.5 The 1996 Act makes provisions concerning how protected disclosures should be made, and circumstances in which a disclosure will not constitute a protected disclosure, for example if the individual making the disclosure commits an offence by doing so. It also specifies a range of persons to whom a worker can make a disclosure that would qualify for protection. This includes the worker's employer, or the employer's agent and prescribed persons. A prescribed person can be either an individual or an organisation included in a list made by order of a Secretary of State[26]. Disclosures to prescribed persons will be protected if the person making the disclosure meets certain specified requirements,[27] including that they reasonably believe that the information and any allegation is substantially true.

2.2.6 Disclosures can also be made wider than the range of persons specified in the 1996 Act, for example to the police or to the media. However, there are additional conditions that need to be satisfied before a worker making a wider disclosure would be protected under the 1996 Act. In all the circumstances of the case it must be reasonable for the worker to make the disclosure. In addition one of three further conditions must be met, namely:

- that, at the time the disclosure is made, the worker reasonably believes that they will be subjected to a detriment by the employer if they raise a concern with them, or
- where there is no prescribed person to which a disclosure can be made in relation to the relevant failure, the worker reasonably believes it is likely that evidence relating to the relevant failure will be concealed or destroyed if they make a disclosure to the employer, or
- that the worker has previously made a disclosure of substantially the same information to his employer, or a prescribed person.

2.2.7 Unlawful detriments suffered as a result of making a protected disclosure could include bullying, harassment or victimisation, or discrimination in terms of promotion or other career progression opportunities. Similarly, an employee will be able to claim unfair dismissal if he/she can show that the reason, or principle reason, for the dismissal was that he/she had made a protected disclosure.[28] In addition, where an employee resigns because of bullying or harassment as a result of making a protected disclosure he/she may also make a claim for unfair dismissal if he/she can show that the employer was either complicit in the bullying or did not take appropriate steps to prevent it. Bullying does not have to be related to having made a protected disclosure, so a claim for unfair dismissal could also be invoked in other circumstances.

2.2.8 A worker who believes they have suffered an unlawful detriment as a result of making a protected disclosure may make a claim to an Employment Tribunal (ET)[29] against the employer and/or the employee or agent of the employer alleged to be responsible for the detriment. For any unlawful detriment short of dismissal, the remedies available are a declaration that the complaint is well founded, and an award of compensation.[30] For a finding of unfair dismissal, the remedies are an award of compensation[31] and an order for reinstatement or reengagement.[32] However, the employer is not legally obliged to comply with such an order. Where they do not, a further award of compensation can be made, unless the employer satisfies the ET that it was not practical to comply with the order.[33]

26 The current list can be found at: https://www.gov.uk/government/publications/blowing-the-whistle-list-of-prescribed-people-and-bodies--2
27 Employment Rights Act 1996, section 43F
28 Employment Rights Act 1996, section 103A
29 Employment Rights Act 1996, section 48(1A)
30 Employment Rights Act 1996, section 49(1). The compensation is subject to a statutory maximum, and may be reduced if the Tribunal is satisfied that the disclosure was not made in good faith (section 49(6A)
31 Employment Rights Act 1996, section 112
32 Employment Rights Act 1996, section 113
33 Employment Rights Act 1996, section 117

2.2.9 These provisions are often portrayed as 'protections' for whistleblowers, perhaps understandably so, given that the legislation is couched in terms of making 'protected' disclosures. However this is not an accurate description. The legislation does not provide an individual worker with guaranteed protection from suffering detriment if they make a protected disclosure, and contains no measure capable of preventing such detriments occurring. Instead it confers on workers a right not to be subjected to such detriment and gives them a route to obtain remedies if that right is violated. It must be said, however, that those remedies are relatively restricted. Furthermore, since the introduction in July 2013 of fees for bringing ET claims, there has been a significant reduction in the number of cases brought[34]. It looks like the cost has, perhaps not unexpectedly, acted as a deterrent to making such claims.

2.2.10 The Enterprise and Regulatory Reform Act 2013 ('the 2013 Act') introduced significant changes to the 1996 Act[35]. In particular, it introduced vicarious liability for the bullying or harassment of whistleblowers. Where there is any bullying or harassment of a worker by a fellow worker or by an agent of the employer on the ground that he/she has made a protected disclosure, this will be treated as having been done by the employer. In addition, the requirement to make disclosures 'in good faith' was removed,[36] although this was coupled with new powers for the ET to reduce the amount of compensation awarded where it determined that the protected disclosure in question was not made in good faith. There is also a requirement that the worker reasonably believes the disclosure to be in the public interest. Specific to the NHS, the meaning of 'worker' was extended by the addition of further types of NHS contract to include, for example, those working in primary care such as self-employed GPs and pharmacists[37].

Confidentiality clauses

2.2.11 A further significant provision in the 1996 Act relates to confidentiality clauses within a settlement agreement or employment contract. Any such clause is deemed void if it purports to prevent those signing these agreements from making protected disclosures in the public interest.[38] Such clauses are often referred to as 'gagging clauses', but there is some confusion as to what this actually means. The provision refers specifically to clauses that purport to prohibit a worker from making a protected disclosure. It does not cover clauses that impose on either or both parties to the agreement or contract a duty to maintain confidentiality in other respects, such as in relation to financial details or the personal details of third parties.

Equality Act 2010

2.2.12 The Equality Act 2010 makes it illegal to discriminate against someone with a protected characteristic[39] such as race, age, and religion. The law also protects from discrimination someone who complains about discrimination or supports someone else's claim, and prohibits harassment or victimisation of anyone who holds a protected characteristic. Making or having made a protected disclosure under the provisions of the 1996 Act is not a protected characteristic under this legislation.

2.2.13 A significant difference between the provisions of the Equality Act and those of the 1996 Act is that the Equality Act is not confined to employment or quasi-employment relationships. Thus it can, and does, have effect in respect of recruitment practices, making it unlawful to deny an individual a job for which they are otherwise the best candidate solely or mainly because they hold a particular protected characteristic.

34 Employment Tribunal Receipt Statistics (Management Information: July to September 2013), Ministry of Justice, 18 October 2013
35 Enterprise and Regulatory Reform Act 2013, sections 17 to 20
36 Enterprise and Regulatory Reform Act 2013, section 18
37 Enterprise and Regulatory Reform Act 2013, section 20
38 Employment Rights Act 1996, section 43J
39 The protected characteristics are: age; disability; gender reassignment; marriage and civil partnership; race; religion or belief; sex; and, sexual orientation

2.3 Individual and organisational responsibilities

2.3.1 A range of measures are in place or are about to be put in place to help enable or ensure staff speak up. Some have been in place for some time and others are recent additions where it is too early to assess their impact. Some examples include:

- professional duties to raise concerns
- NHS terms and conditions[40] and the NHS Constitution[41]
- incident reporting and investigation obligations
- statutory duty of candour
- Fit and Proper Person Test (FPPT).

Professional duties to raise concerns

2.3.2 Regulated healthcare professionals have long had a professional duty to be candid with patients and service users about all avoidable harm. However, messaging and guidance from the professional regulators appears to have been inconsistent. In conjunction with the establishment of the statutory duty of candour on provider organisations, the professional regulators have now come together to strengthen references to candour in professional regulation guidance. These regulators are listed in the glossary at Annex E.

2.3.3 Led by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), on 3 November 2014, the professional regulators launched a public consultation on joint guidance that will place honesty at the heart of healthcare and will put this important professional duty firmly into practice.

2.3.4 The proposed guidance calls on NHS organisations and their clinical leaders to support healthcare professionals by creating open and honest learning cultures in the work place. Regulated healthcare professionals will have to be candid with patients and service users about all avoidable harm. Obstructing colleagues in being candid would constitute a breach of the professional codes.

2.3.5 The professional codes also place professional obligations on registrants to inform employers of untoward incidents. The professional regulators are also reviewing their guidance to professional misconduct panels to ensure that they take proper account of whether professionals have raised concerns promptly.

NHS terms and conditions and the NHS Constitution

2.3.6 NHS employees have a contractual right and duty to raise concerns. In July 2010 changes were made to the NHS staff terms and conditions of service handbook to include that right. Similarly, the handbook includes an expectation that employers adopt policies that encourage staff to exercise that right. Through the NHS Constitution it is made clear that workers are expected to exercise their right to raise concerns as early as possible. In return, the NHS pledges to support all workers in doing so and to respond to and, where necessary, investigate the concerns raised. It is not only NHS staff who are required to take account of the NHS Constitution. All providers of NHS services are required, through the NHS standard contract, to take account of it, thereby extending those expectations and pledges to those that work within but are not directly employed by the NHS.

40 NHS Terms and Conditions Service Handbook, 2014
41 NHS Constitution for England, last updated August 2014

Extracts from the Terms and Conditions Handbook

- All employees working in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.[42]
- NHS organisations must have local policies that emphasise that it is safe and acceptable for staff to raise concerns and set out clear arrangements for doing so. Such policies are often referred to as 'whistleblowing' or 'open practice' policies.[43]
- [local policies should include the following point…] it is a disciplinary matter either to victimise a genuine 'whistleblower' or for someone to maliciously make a false allegation. However, every concern should be treated as made in good faith, unless it is subsequently found out not to be.[44]

Extract from the NHS Constitution

- Staff should aim to raise any genuine concern [they] may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest reasonable opportunity.[45]

Incident reporting and investigation obligations

2.3.7 NHS England has a statutory function to 'give advice and guidance, to such persons as it considers appropriate, for the purpose of maintaining and improving the safety of the services provided by the health service'[46].

2.3.8 It fulfils that function through the National Reporting and Learning System (NRLS), a service that collates health service incident data. All incidents classified as having caused severe harm or death are individually analysed. There are around 250-400 reports per week. Similarly, aggregate data from all reports received by NRLS (circa 1.4 million per year) are assessed and, where learning from an incident could be beneficial, recommendations for preventing such incidents occurring in the future are shared nationally.

2.3.9 Local Risk Management Systems (LRMS) feed information into the NRLS. All trusts have systems, such as Datix, Sentinel and Ulysses, in place for the recording of incidents and will have local policies relating to when and by whom reports can be made. The Care Quality Commission (CQC) treats failure to upload concerns from LRMS at least monthly, or implausibly low rates of reported concerns, as a 'risk' or 'elevated risk' in its Intelligent Monitoring System.

Statutory duty of candour

2.3.10 Regulations implementing the statutory duty of candour came into effect for NHS healthcare bodies on 27 November 2014[47]. Subject to further legislation, which the Government expects to lay in early 2015, the duty will be extended to all providers registered with the CQC from April 2015.

2.3.11 The duty of candour requires NHS bodies to be open and honest with people. Where, in the view of a healthcare professional, an unintended or unexpected incident has resulted in, or could still result in, death, severe or moderate harm, or prolonged psychological harm to a patient, the regulations prescribe a formal set of notification procedures that the provider must follow when informing the patient, or their representative, of that harm.

2.3.12 Providers must notify the patient, give an apology and follow up the incident in writing. The

42 *NHS Terms and Conditions of Service Handbook, section 21.1 Pay Circular (A for C) 4/2014*
43 *NHS Terms and Conditions of Service Handbook, section 21.2 Pay Circular (A for C) 4/2014*
44 *NHS Terms and Conditions of Service Handbook, section 21.3 Pay Circular (A for C) 4/2014*
45 *NHS Constitution for England*, p15
46 National Health Service Act 2006 section 13R(4) as amended by Health and Social Care Act 2012
47 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. No. 2936)

duty does not apply to individuals, but to provider organisations. However, in practice the task of being open with patients will be carried out by individual staff, and organisations are expected to consider what additional support and training they need to provide to staff to comply with the requirements of the duty.

2.3.13 Compliance with the duty will be part of a provider's CQC registration requirement, and CQC will be able to use its enforcement powers if necessary. This could include bringing a prosecution against a non-compliant NHS provider, or, in the worst cases, cancelling registration.

Fit and Proper Persons Test

2.3.14 It is already the case that NHS bodies must take steps to ensure that staff are fit and proper persons for the role they are being employed to undertake. The same regulations that impose the statutory duty of candour also introduce a new requirement on NHS bodies to ensure that their board-level directors (or equivalents) are fit and proper persons for their role. The timescales for implementation are the same as for the duty of candour.

2.3.15 The criteria for eligibility as a director includes a requirement that they must not have been responsible for, or have permitted or colluded in, any serious misconduct or mismanagement, in the course of carrying out an activity regulated by CQC. This could be particularly significant in the context of whistleblowing, where directors are sometimes alleged to have been responsible for victimisation of the whistleblower or failing to act appropriately when such victimisation occurs.

2.3.16 The regulations require providers to give CQC evidence to assess whether the Fit and Proper Person Test (FPPT) has been properly applied. However, they also allow CQC to take action in respect of an individual they deem to be an unfit director, including requiring the provider to remove the individual from the post if considered appropriate.

2.4 Roles and responsibilities of regulators and others

2.4.1. This section covers:

- system regulators
- professional regulators
- other bodies.

It does not cover all organisations with a role in raising concerns but highlights some of the key players.

System Regulators

Care Quality Commission (CQC)

2.4.2 CQC is the independent regulator of health and social care in England. Its role is to make sure that hospitals, care homes, dental and general practices and other care services in England provide people with safe, effective and high-quality care, and to encourage them to make improvements.

2.4.3 All organisations that carry out 'regulated activities' as prescribed by the Health and Social Care Act 2008 are required to be registered with the CQC. Regulated activities include most healthcare and adult social care services. Registration is dependent on meeting a range of registration requirements, and the CQC regularly inspects registrants to satisfy itself that they continue to meet those requirements.

2.4.4 A number of changes have been made to the way CQC operates in the wake of the public inquiry into the failings in Mid Staffordshire. Three new roles, Chief Inspector of Hospitals, Chief Inspector of Primary Care and Chief Inspector of Adult Social Care have been tasked to ensure that inspections will no longer be seen as just a 'tick box' exercise.

2.4.5 In addition, CQC has developed a new inspection framework which sets out five 'domains' against which to assess providers. These are whether they are: safe; effective; caring; responsive to people's needs; and well-led[48]. Significantly, the well-led domain covers the leadership and culture of a provider, not just its governance arrangements.

48 *Raising standards, putting people first: Our strategy for 2013 to 2016*, Care Quality Commission

In hospital inspections in particular, the inspection process includes discussions about how the organisation deals with concerns and handles whistleblowers. Following inspections, providers are given a rating: outstanding; good; requires improvement; or inadequate. The inspection report also identifies any non-compliance with regulatory requirements and what action has been taken or is required as a result.

2.4.6 From April 2015, twelve 'Fundamental Standards' of care will come into effect for all CQC registered providers of healthcare services. Inspections will look to assess whether these standards are being met. Of particular relevance to this Review are the requirements that:

- care and treatment must be provided in a safe way for service users. In order to comply, among other things, providers must do all that is reasonably practicable to mitigate risks to health and safety, and ensure that staff have the necessary competence, skills and experience to provide the service safely[49]
- service users must be protected from abuse and improper treatment by the establishment and effective operation of systems and processes to investigate, immediately upon becoming aware of any allegation or evidence of such abuse[50]
- systems or processes must be established and operated effectively which, among other things, assess, monitor, and improve the service's quality and safety, and seek and act on feedback on the service for the purpose of continually evaluating and improving it[51]
- sufficient numbers of suitably qualified, skilled and experienced staff must be deployed to meet the requirement of the Fundamental Standards, and such persons must receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to perform their duties[52]
- staff employed by the service must have the necessary skills and competence, and where a person employed no longer meets that requirement the provider must take such action as is necessary and proportionate to ensure that the requirement is met.[53]

2.4.7 Every registered healthcare provider of NHS services will have to comply with these requirements, and the CQC will be monitoring and, where appropriate, enforcing compliance. CQC will have a range of enforcement options available to it in the event of non-compliance, including, in extreme cases, prosecution or withdrawal of registration. NHS staff will have a major role to play in ensuring that providers meet these obligations, as well as the duty of candour referred to in 2.3.[54]

2.4.8 CQC is also a prescribed person for the purposes of the 1996 Act (see 2.2). It therefore receives and has mechanisms in place to respond to concerns raised with it. In 2012 following a review of its National Customer Service Centre processes, CQC set up a dedicated Safety Escalation Team to receive concerns from NHS and social care workers as well as members of the public. This Safety Escalation Team (SET) ensures all high risk information is processed and forwards whistleblowing concerns to the local inspectors. The SET monitors the progress of the concern until there is a final outcome.

Monitor

2.4.9 Monitor is the sector regulator for health services in England. Its responsibilities include ensuring that: independent NHS foundation trusts are well-led so that they can provide quality care on a sustainable basis; essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and procurement, choice and competition operate in the best interests of patients.

49 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936), reg 12
50 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936), reg 13
51 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936), reg 17
52 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936), reg 18
53 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936), reg 19
54 The duty of candour appears in regulation 20 of the 2014 regulations

2.4.10 Monitor is a prescribed person for the purposes of the 1996 Act. Its website contains information and guidance[55] for NHS workers who wish to raise concerns with it. The guidance requires that concerns about an organisation are set out fully and as clearly as possible, stating:

- the issue(s) that have arisen, with a view on which of its activities the concerns relate to
- to which part or parts of the whistleblowing legislation the concerns relate
- where concerns have already been raised with an employer, what happened as a result.

2.4.11 Monitor's guidance states that any action taken on information disclosed to it will depend on whether it falls within its scope to act on, and if so, Monitor's assessment of the seriousness of the concern raised. If satisfied that it is within their remit to act, Monitor will generally do one or more of the following:

- make a record of the concerns to add to its database of information about organisations covered by its regulatory duties
- raise the issue directly with the organisation if this is considered appropriate
- notify another regulator or official body if it is appropriate for it to look into the concern instead of, or as well as, Monitor.

NHS Trust Development Authority

2.4.12 The NHS Trust Development Authority (NHS TDA) is a Special Health Authority responsible for providing leadership and support to those NHS trusts that are still working towards foundation trust status. Its key functions include:

- monitoring the performance of NHS trusts, and providing support to help them improve the quality and sustainability of their services assurance of clinical quality, governance and risk in NHS trusts
- supporting the transition of NHS trusts to foundation trust status
- appointments to NHS trusts of chairs and non-executive members and trustees for NHS Charities where the Secretary of State has a power to appoint.

2.4.13 The NHS TDA was added to the list of prescribed persons for the purposes of the 1996 Act in October 2014. It is currently developing its procedures and policies for dealing with protected disclosures made to it. Its website confirms its commitment in general terms to treating all concerns raised with it with fairness and transparency and in line with legislation. To do this, the NHS TDA states that it will work closely with the CQC and NHS trusts as necessary. If the NHS TDA decides that the concern would be better addressed by another body, it may pass the information on to them – if it does, it commits to letting the person who raised the concern know.

Professional regulators

2.4.14 Most healthcare professionals are required to be registered with the relevant professional regulator in order to practise in the UK. The regulators require compliance with codes of conduct, and have powers to investigate allegations of misconduct or malpractice that call into question the fitness to practise of an individual. Reports of alleged misconduct or malpractice may be made by employers, other healthcare professionals, patients or members of the public.

2.4.15 As indicated in 2.3, the professional codes place obligations on registrants to report untoward incidents to their employers, and failure to do so may itself amount to professional misconduct.

2.4.16 All the professional regulators are prescribed persons for the purposes of the 1996 Act, and must therefore have arrangements in place to deal with protected disclosures made to them. There is some evidence from the contributions received by the Review that the professional regulators tend to respond to such disclosures by instigating formal fitness to practise proceedings, which do not necessarily prioritise ensuring that the initial concern about patient safety risks are quickly and effectively dealt with.

55 *External Whistleblowing (Protected Disclosures) Policy*, Monitor, Revised October 2013

Other bodies

Health Education England

2.4.17 Health Education England (HEE) was established as a Special Health Authority in June 2012. It provides leadership for the new education and training system by ensuring that the shape and skills of the future health and public health workforce evolve to sustain high quality outcomes for patients in the face of demographic and technological change.

2.4.18 HEE is not a prescribed person for the purposes of the 1996 Act. However, its 2014/15 Mandate requires development of minimum mandatory training requirements with specific reference to training staff on how to raise concerns about patient care or safety.

NHS Protect

2.4.19 NHS Protect, a subdivision of the NHS Business Services Authority, is the lead organisation for receiving and investigating allegations of fraud, bribery, corruption and other unlawful activity (such as market fixing) in the health service. Each organisation has responsibility to carry out these functions locally, whilst NHS Protect aims to:

- educate and inform those who work for or use the NHS about crime in the health service and how to tackle it
- prevent and deter crime in the NHS by removing opportunities for it to occur or to re-occur
- hold to account those who have committed crime against the NHS by detecting and prosecuting offenders and seeking redress where viable.

2.4.20 NHS Protect is not a prescribed person for the purposes of the 1996 Act.

Royal Colleges

2.4.21 There are a number of medical Royal Colleges across the UK which offer an Invited Review Mechanism. These reviews are requested by organisations rather than individuals and generally relate to the performance of a particular unit or department. The resulting recommendations go to the trust management although issues of serious concern can be referred to a professional or system regulator.

NHS England and Clinical Commissioning Groups

2.4.22 NHS England funds clinical commissioning groups (CCGs) who commission services for their local communities. NHS England also directly commissions some specialist services on a national basis.

2.4.23 Both NHS England and CCGs are responsible for promoting the NHS Constitution and play a vital role in setting the values and organisational norms across the NHS as a whole. As commissioner and 'payer', NHS England and CCGs are responsible for defining the relationships between providers and other organisations in the health service and the way these relationships work. Their role in terms of staff concerns is still emerging following the recent health service restructure. Neither is a prescribed person for the purposes of the 1996 Act.

2.4.24 There is a mandate from the Government to NHS England which sets out the strategic direction for NHS England and ensures it is democratically accountable. It is the main basis of Ministerial instruction to the NHS. Point 5 of the mandate is about treating and caring for people in a safe environment protected from avoidable harm.

Extracts from 2015/16 Mandate:

5.2 Improving patient safety involves many things: treating patients with dignity and respect; high quality nursing care; creating systems that prevent both error and harm; and creating a culture of learning from patient safety incidents, particularly events that should never happen, such as wrong site surgery, to prevent them from happening again.

5.3 NHS England's objective is to continue to reduce avoidable harm and make measurable progress in 2015/16 to embed a culture of patient safety in the NHS including through improved reporting of incidents.

2.5 National initiatives in raising concerns

2.5.1 There are a number of recent, current or planned initiatives that will directly or indirectly have an impact on the climate surrounding or the process of raising concerns. Examples are:

- a **'Speaking Up' Charter**[56] launched in the summer of 2012 by NHS Employers, the organisation that represents employer bodies within the NHS. The Charter encouraged organisations to pledge publicly a commitment to help create cultural change including continuous review and evaluation of raising concerns policies to ensure they remain effective.
- **Caremakers** – this concept was developed in December 2012 based on the 2012 Olympic and Paralympic 'Games Makers'. Students and newly qualified nurses can become caremakers to promote health and well-being and restore morale and pride in nursing. They also promote the 6Cs – care, competence, compassion, communication, courage and commitment. Courage can include courage to speak up and courage to change, learn and challenge how care is delivered.
- The **Sign Up to Safety Campaign** launched in June 2014. This campaign's three year objective is to reduce avoidable harm by 50% and save 6,000 lives. Organisations and individuals who sign up to the campaign commit to setting out actions they will undertake in response to the following five pledges:
  1. **Put safety first**. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
  2. **Continually learn**. Make their organisations more resilient to risks, by acting on feedback from patients and by constantly measuring and monitoring how safe their services are.
  3. **Honesty**. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
  4. **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
  5. **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.
- **Commission on Education and Training for Patient Safety** established by Health Education England in August 2014. It is chaired by Professor Sir Norman Williams, who is also acting as one of the Advisors to this Review. One of the Commission's key strands of work will be to examine how to support all staff, through training, to raise and respond to concerns about patient safety. The Commission is due to report in autumn 2015.
- **Safety Fellowships programme** being led by NHS England, working with the Health Foundation. This is starting early in 2015 and aims to recruit 5,000 Safety Fellows by 2020. The intention is to recruit experts in quality and wider improvement as participants in the initiative. Participants will work collaboratively through networking and development activities to address a number of significant challenges to making care safer.

2.5.2 The Review also learned about many local initiatives to improve the raising of, and learning from, concerns. These included campaigns to encourage speaking up, cultural ambassador style roles to support staff raising concerns and a range of mechanisms to provide feedback to staff about concerns that had been raised and action taken as a result. Examples of local initiatives are included in chapters 5–7. These are welcome and will undoubtedly make a difference. The evidence in chapter 3 however, indicates that these are still at an early stage and not universal.

56 *Speaking up Charter*, NHS Employers, 20 June 2014

2.6 Guidance and advice for staff raising concerns

2.6.1 There are already several sources of guidance and advice for staff on how to go about raising concerns including:

- **NHS terms and conditions of service handbook and NHS Constitution** – section 2.3 mentioned that this handbook sets out the expectation that NHS employers should have local policies and procedures in place, and offers suggestions on what those policies should contain. It also noted that the NHS Constitution set out expectations in this area.
- **guidance from regulators** – many of the system and professional regulators provide guidance and advice relevant to staff considering raising concerns including their own roles, if any, within that process.
- **guidance from professional bodies** – a number of Royal Colleges and professional bodies provide advice and guidance to their members about where to go and the process to follow if they have concerns.
- **Whistleblowing Helpline** – commissioned by the Department of Health provides free advice and support to healthcare workers who are wondering whether or how to raise a concern at work, as well as to people who are further on in the whistleblowing journey. The Helpline also provides advice and training on best practice to NHS managers, employers, professional bodies and trade union representatives. In a typical month, it answers over 50 calls relating to the NHS and receives over 3,000 hits on its website. It is not a disclosure line and does not offer an advocacy service. Its website offers factsheets, toolkits and resources to inform staff and managers in a practical way about the 1996 Act and how to take a positive approach to whistleblowing. It published updated guidance in March 2014 for employers, managers and workers on raising concerns at work.
- **Public Concern at Work** – a charitable organisation that provides an advice helpline which extends to offering independent legal advice.
- **Model policy** – first introduced into the NHS in 2003 and published in guidance 'Speak Up for a Healthy NHS' produced by Public Concern at Work. The Whistleblowing Helpline published a revised model policy in its guidance 'Raising concerns at work' in March 2014 along with a flow chart to help staff and employers understand the process of raising concerns.

2.6.2 There is a risk that such a plethora of information, advice and guidance and the various ways it can be obtained may be confusing for NHS workers with concerns. They might not know where to go for the best advice or whether, having spoken to any particular organisation, they still need to report their concerns elsewhere; or whether even speaking to that organisation had affected their rights under the 1996 Act. There is also the risk of conflicting advice, including different definitions of the term 'whistleblowing'.

2.7 Conclusion

2.7.1 This brief review is not a detailed analysis of the legal and policy context, but is sufficient to illustrate the complexity of the current position. The quantity of activity in the fields of legislation, policy and guidance indicate a continuing institutional recognition that more needs to be done to support the freedom of staff to speak up, and concern that the measures already in place are insufficient. This has resulted in a somewhat piecemeal and reactive approach to this issue.

2.7.2 Particular issues are:

- the law seeking to protect whistleblowers is cast entirely in an employment context. It proceeds from an assumption that an exception needs to be made to a general requirement to keep the affairs of the employer confidential, rather than from an acceptance that all those providing a public service have a duty to raise concerns which affect the public interest. It is complex and offers limited retrospective remedies for victimisation
- all NHS employers are required to have policies which encourage or require their staff to speak up but there is no requirement for uniformity
- there are many sources of guidance, all expressing themselves differently.

3

Evidence from contributors

3.1 Introduction

3.1.1 To inform the Review, I was keen to hear from as many individuals and organisations as possible who had experience of, or an interest in, raising concerns and the whistleblowing agenda. As described in chapter 1, this was achieved in a number of ways:

- a call for written contributions to enable individuals and organisations with experience of, or views on, raising concerns and making disclosures in the public interest to share their experiences, views and ideas. We received over 650 contributions (612 from individuals and 43 from organisations – See Annex C). We reviewed all the contributions. A thematic review was also undertaken by independent researchers of over 400 of the responses received from individuals which were in a format the researchers could analyse. The contributors were a self-selecting group and therefore not statistically representative. However, the contributions were a rich source of information about the experiences of a broad range of NHS staff.
- a series of private meetings and workshops with over 200 people including:
  - individuals who wrote to the Review to explore their experiences and ideas in more detail
  - organisations with a role to play in supporting an open and honest culture, including employers, professional bodies, system and professional regulators , trade unions and the legal profession
  - particular staff groups (trainee doctors, student nurses and doctors from black and minority ethnic groups) to understand better their perspectives.
- four seminars attended by a total of 100 people to review and discuss issues and emerging themes.
- a confidential online survey of staff in NHS trusts and in primary care (GP practices and community pharmacies), employers and associated organisations such as system and professional regulators. As with all surveys of this type, the findings must be interpreted with some caution for a variety of reasons (for example, self-selection bias and distribution issues). Nonetheless 19,764 staff responded, 15,120 from NHS trusts and 4,644 from primary care. The responses provide a valuable source of triangulation with other sources of evidence.
- qualitative research involving a desk analysis of a small sample of NHS whistleblowing policies and an interview-based analysis of how such policies are implemented in the NHS.
- desk analysis about whistleblowing in other sectors and in other countries.

3.1.2 The research and seminar reports are available at www.freedomtospeakup.org.uk. A summary of the responses from the surveys taken into account in this chapter are set out at Annexes Di, Dii and Diii.

3.1.3 This chapter draws together key messages from these sources of information. It sets out what I heard from:

- employees and former employees (see 3.2)
- employees from a BME background (see 3.3)
- employers (see 3.4)
- professional bodies including Royal Colleges (see 3.5)
- regulators (see 3.6)
- trade unions (see 3.7)
- other sectors (see 3.8)
- other countries (see 3.9).

3.1.4 Where possible, the messages are grouped under four headings: overarching issues such as culture; raising concerns; handling concerns; and resolving concerns.

3.1.5 My conclusions are based on this evidence and other related evidence. They are summarised in chapter 4 and expanded on in chapters 5-9.

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3.2 Employees and former employees

Introduction

3.2.1 The majority of written contributions sent to the Review were from individuals who had experience of raising concerns or the organisations representing their interests. This included contributions from family members, former colleagues and people about whom concerns had been raised. A third of the face to face meetings we held were with individuals who had direct experience of raising concerns or having the whistle blown about them. A similar proportion of contributors with direct experience of whistleblowing participated in our seminars.

3.2.2 In total, 19,764 staff responded to our surveys which included 15,120 staff in NHS trusts and 4644 staff working in primary care (general practice and community pharmacies). Not all staff answered every question on the surveys as some were not relevant to them. The baseline number for each question therefore varies. The survey findings that inform this section of the report are set out in Annex Di.

Experiences of whistleblowing

3.2.3 Unsurprisingly given the nature of this Review, positive experiences of whistleblowing were a small minority. They were generally attributed to working in an organisation with a culture of openness, a good knowledge of whistleblowing policies and procedures, feeling supported during the process, and maintaining good working relationships with colleagues.

> *"Consultants took me seriously, handling was exemplary. I was looked after and the episode did me no harm"*

> *"I have raised concerns on many occasions and have had excellent results. I now see it as my role to use my experience and knowledge to support and advise colleagues."*

> *"I had no consequence for raising legitimate concerns – quite the opposite, I was congratulated by my external assessor for doing so at my annual trainees appraisal.[…] I now use my experience to assist in the training of junior doctors on how to raise concerns and keep your job."*

Case Study: A positive experience of raising concerns

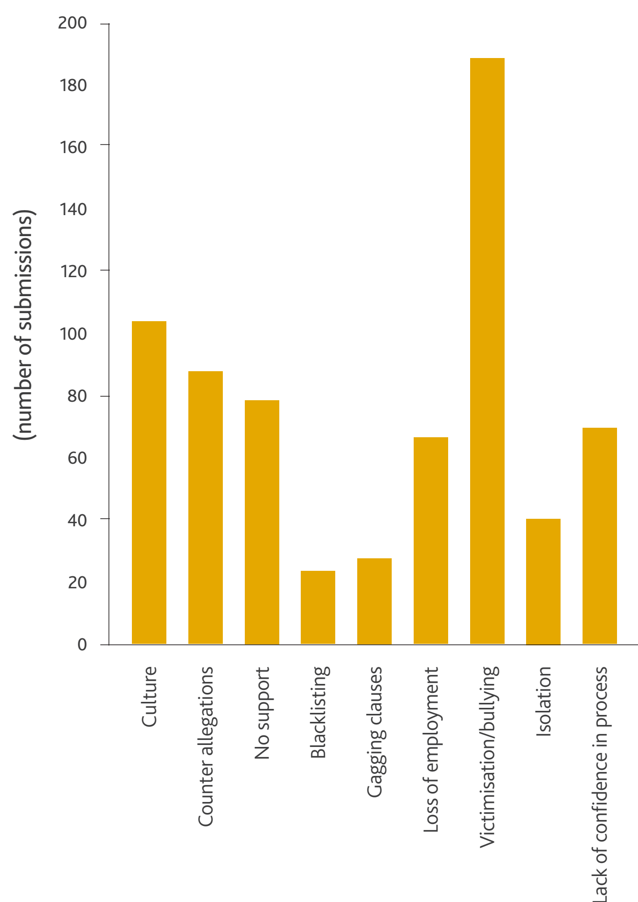
A newly qualified allied health professional (AHP) raised concerns with his supervisor about a senior colleague's behaviour. Professional and managerial leads asked for the concerns to be put in writing. The trust believed there to be merit in the claims and referred the senior professional to their professional regulator.

The AHP gave evidence at the resulting Fitness to Practise hearing and felt supported throughout. The senior clinician left the trust and it transpired that many other staff had also had concerns about that clinician.

The AHP was given space and time to consider the personal and professional impact of the experience.

3.2.4 The vast majority of experiences described were negative. Many were relatively recent or current. This is not about a small number of historic high profile cases from a time when organisations might argue the culture was different. We had a significant number of contributions about cases raised in 2014.

Figure 3a - Problems identified by contributors



Source: Freedom to Speak Up Review call for contributions

Note: Some contributors identified more than one problem in their response.

3.2.5 There were descriptions of what can only be described as a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation. Contributors explained how this could lead to:

- physical and psychological exhaustion
- deterioration of emotional well-being and mental health such as chronic and recurring depression, anxiety, panic attacks and mental breakdown
- professional consequences such as detriment to professional standing and career progression
- impact on employment including suspension or dismissal and the resulting stigma plus possible blacklisting when seeking re-employment
- financial consequences, for example legal fees, and the impact these could have including, in some cases, people losing their homes.

"My experience has been horrific, protracted, and detrimental to my family life, health and professional standing."

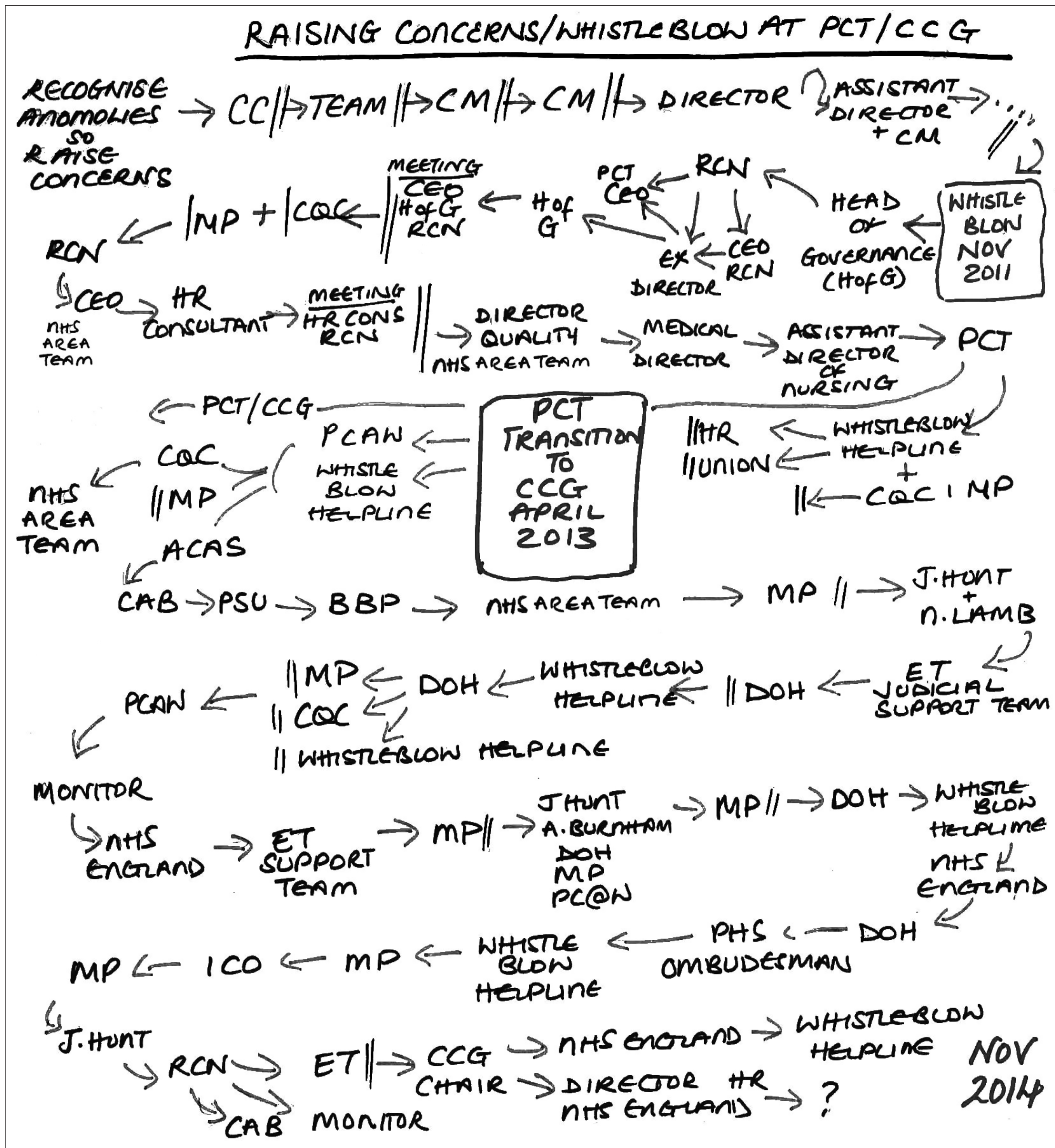
"Making protected disclosures in the NHS has cost me my career. I have been unable to obtain work in my own field since the NHS blacklisted me. I do not receive "unemployment benefits". The bank repossessed my house because the NHS took my job rendering me incapable of making my mortgage payments. […] I get food from the food bank."

"I have often been so depressed by this experience that I have often considered suicide. I live in fear that the hospital will carry out its threat to sue me and take my home from me if I don't pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers)."

"I have suffered serious financial hardship. Finding employment is proving very difficult and I question whether any of it was worth it."

3.2.6 One contributor told us about the process they had followed in pursuit of raising a concern. They produced a flow diagram to show the organisations and individuals that they had contacted to seek advice, raise the concern and ask for help when the concern was ignored. An extract from this diagram has been recreated with permission in figure 3b. It clearly demonstrates how complex the landscape is and just how difficult it can be for staff to be heard.

Figure 3b – Summary of a contributor's experience



3.2.7 The impact on those who were the subject of whistleblowing reports could be as severe, particularly where the allegations made were false or unsubstantiated.

> *"…false allegations made under the cover of whistleblowing have left myself and a number of my colleagues deeply traumatised."*

Overarching issues

Culture

3.2.8 Contributors frequently described a culture of fear, blame, defensiveness and 'scapegoating' when concerns were raised. These perceptions of the culture, real or otherwise, result in some staff refraining from raising concerns.

> *"The reality of a whistleblower in this trust is […] fear, bullying, ostracisation, marginalisation and psychological and physical harm."*

> *"Colleagues often quietly agreed with my concerns but refused to speak out in fear of reprisals."*

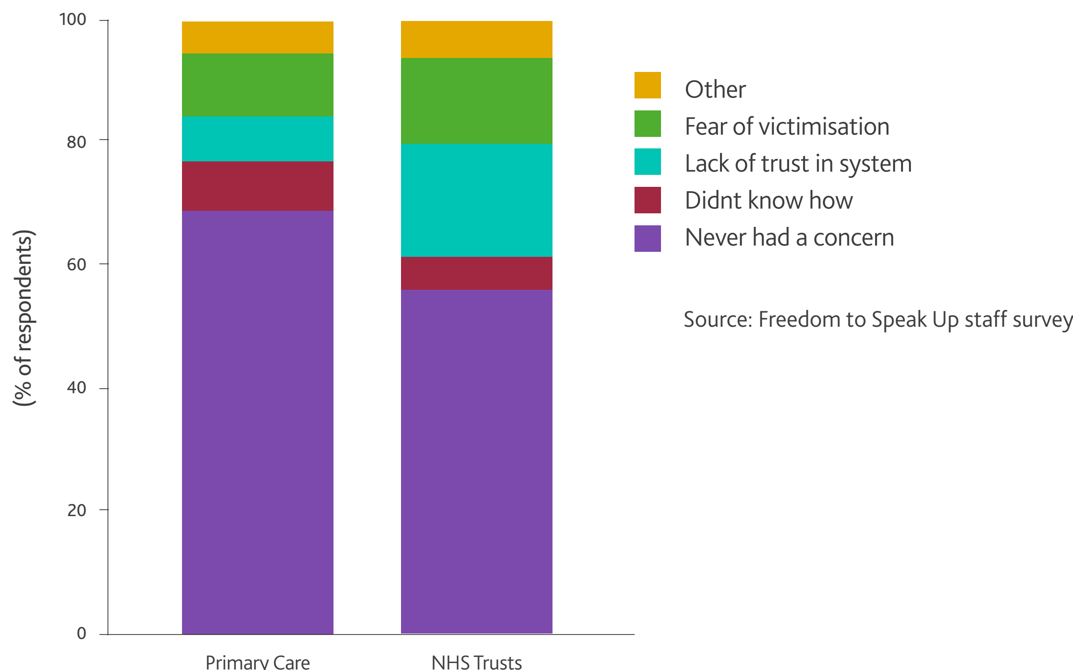
> *"People aren't willing to put their necks on the line for fear they'll lose their heads."*

3.2.9 This was reinforced to some extent by our staff surveys, where a worrying number of staff indicated that they had not raised a concern about wrongdoing in the NHS due to a lack of trust in the system or a fear of being victimised (see Figure 3c).

3.2.10 Our research suggested that this culture might be driven by an old style target-driven leadership focused on firefighting, that blocked a more engagement-driven, compassionate, and values driven leadership.

> *"NHS has a culture of bullying and harassment that means clinicians could not raise issues in clinical care and are pressured to put targets over ethics. If there is such a culture then it is because the majority of managers or clinicians in positions of authority are driving it/managers recruited/ promoted to those positions because of their ability/willingness to push this agenda."*

Figure 3c – Reasons for not raising a concern



Source: Freedom to Speak Up staff survey

3.2.11 When staff did raise concerns they gave examples of being met with denial and resistance.

> *"(There is) a culture of delay, defend and deny."*

> *"I realised the Trust were not reporting and investigating serious incidents appropriately, or at all, […] despite my reminding the various relevant colleagues […] there is still minimisation and indecent haste to spin and shut down scandal."*

> *"It is the suppression of truth by human manipulation that remains the blatant tragedy of what the NHS has now become."*

3.2.12 Some referred to the fear of the consequences after they had spoken up including fear of bullying, harassment and racial discrimination. We heard examples of those fears becoming a reality.

Case Study: Bullying after raising a concern

A healthcare professional described being promoted to a management role within his team and then alerting the trust to procedures that were not being followed. He described how this resulted in 'prolonged rants' and 'personal abuse' and that some staff were bullied into falsifying records to hide failures to follow local and nationally recognised standards. He was told that the issues he was raising would be damaging to the trust if made public and to 'get on with his job'.

He continued to raise his concerns and eventually the trust instigated a review. However, when the report was circulated around his department it was clear, although he was not named, that he had raised the concerns. He was then 'subjected to the most horrendous bullying' by some colleagues. He reported this but no action was taken. He was eventually treated for severe anxiety and off sick for a short while.

Terminology

3.2.13 The hostile culture described above was likely to have been reinforced by the negative language often used in reference to speaking up. Contributors described how those who raised a concern, whether internally or externally, were often seen as 'troublemakers' or 'back stabbers'. Some suggested different words should be used such as 'raising concerns champion'.

> *"Anyone who blows the whistle is seen as a snitch and is punished."*

3.2.14 At the seminars there was widespread confusion about the meaning of the term 'whistleblowing' and its relationship to a protected disclosure, but there was agreement that the term had negative connotations. It was stressed that people who raise concerns do not always think of themselves as whistleblowers. Some contributors wanted the words whistleblower and whistleblowing changed.

> *"If the outcome of your report is to find a way to create a more transparent and caring NHS then from my experience I would suggest that rather than asking for people to 'Blow the Whistle' you should be asking them to 'Protect their patients'."*

3.2.15 Others did not see the value in changing terms. The general consensus at the seminars was to focus on changing the negative perception associated with the term rather than the term itself.

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Raising Concerns

Policies and procedures

3.2.16 Whilst the majority of staff are aware of their local whistleblowing policies and procedures, a significant minority are not. At the seminars there were calls for greater standardisation of policies and procedures across the NHS.

> *"Why does each Trust have their own policy rather than a generic approved policy that is clear and user friendly?'."*

Seeking advice about concerns/raising concerns

3.2.17 If staff seek advice before raising a concern, our surveys indicated that most go to a work colleague. Trade unions and professional bodies were the next most favoured sources for staff in trusts, whereas in primary care a professional body or friends and family were used. External helplines did not appear to be commonly used.

Where staff raise concerns first

3.2.18 Whistleblowing policies considered by the Review encouraged raising concerns verbally with the line manager in the first instance and putting concerns in writing beyond that. Our evidence showed that this was what staff tended to do when raising a concern.

Raising concerns anonymously

3.2.19 There was strong evidence that staff liked to have the option to raise concerns anonymously. However, there are risks that a staff member, especially if they work in a small organisation or department, could be identified.

> *"…I have raised concerns with the CQC (anonymously), but am now reluctant to do so again. In order to give enough details about a problem for the CQC to investigate, it invariably means that the people in possession of such knowledge may be fairly easy to identify by the hospital managers. This has led to me being threatened and bullied by managers who are fairly sure it must have been me supplying some of the information. The only safe way to raise concerns without fear of reprisals is therefore to give less supporting detail which in turn makes it less easy for the CQC to investigate and easier for the trust to refute or hide."*

Raising concerns externally

3.2.20 The majority of trust staff who raise a concern internally do not appear to then take it outside of their organisation. The reasons for this are not clear but one might assume this is either because it has been dealt with satisfactorily or the person decided not to pursue it further. Our survey indicated that staff in primary care are more likely to take a concern outside.

3.2.21 Where employees did raise concerns externally, the decision did not appear to have been made rashly. Rather, it was considered when staff had given up hope that the organisation was able or willing to take action. Lack of confidence in the process, worries about potential career impact and dissatisfaction with the outcome of the internal procedures were potential factors behind their decision highlighted by our surveys.

3.2.22 When concerns were raised externally, trust staff were most likely to refer their concerns to a trade union or professional body, whereas primary care staff appeared to prefer either a professional body or a regulator.

3.2.23 Staff rarely chose the media for raising concerns. Indeed most told us they preferred to avoid media coverage. Some staff who had been the subject of media coverage considered they were treated unfairly and in a sensationalistic manner.

"…sensationalist media stories have unfairly threatened public confidence in our clinical services."

Handling Concerns

3.2.24 A significant proportion of staff do not use an employer's formal procedure to raise a concern although the reason for this is not clear. Where 'whistleblowing' policies and procedures were used locally, some staff described poor implementation and indicated that this exacerbated problems with handling concerns.

Retaliatory Action

3.2.25 We heard that whistleblowers could be subjected to performance management or referral to their professional regulator rather than an investigation of their concerns.

"(there is a) culture of putting blame back on the person raising serious concerns."

Training

3.2.26 Strong views were expressed at seminars that training in raising or handling concerns was inadequate.

Logging concerns

3.2.27 Some employees suggested that managers who receive concerns should make a written record that the concern has been raised and share this with the person who raised it. This was thought to be necessary to prevent cover-ups and denials later down the line. It also appeared that staff wanted concerns to be logged to ensure that they were addressed and did not get forgotten.

Support after raising a concern

3.2.28 Our evidence strongly indicated that whistleblowers were not offered any meaningful support by their employer. People felt a sense of isolation once they had raised a concern, particularly if they were moved away from their usual place of work or 'given' special leave. They told us that they had no clearly designated member of staff they could talk to or who would take responsibility for implementing change as a result of their concern.

"I proposed a review of the model. This was dismissed and I began to be excluded and isolated."

"I remained off sick, upset, and confused about what to do next."

3.2.29 Some saw benefit in a 'champion' style role, someone they could go to with concerns and who could support them if they pursued their concerns.

"I also think that a system could be put in place for all trusts to engage a staff member as an Ambassador for Cultural Change. They could be the first point of contact for staff who wish to whistleblow safely."

3.2.30 Whilst it may be good practice to offer support at the point at which a concern is raised, some staff may not be aware that they want or need support until the process is underway. It was suggested that support needed to be proactively offered and kept under review.

3.2.31 There were some concerns about a power balance too strongly in favour of the trust, particularly in terms of finances and legal support.

"David vs Goliath fight for justice – NHS organisations appoint highly paid lawyers to undermine the Public Interest Disclosure Act and I had to fund my legal fees."

Investigation process

3.2.32 Cases could be long running and remain unresolved for months and even years. Delays in the process for handling and investigating concerns had a huge impact on individuals, particularly if they were suspended or on special or sick leave. This included an increased sense of isolation, stress and in some cases mental health issues. Delays also reduced the possibility of establishing the facts of the case.

> *"The investigation took far too long – staff had left and memories fade."*

Mediation

> *"The organisation should have an internal mediation mechanism to attempt to resolve the issues. Not all concerns are well-founded. Not all concerns are capable of being resolved with given resources. Nevertheless no concern that indicates genuine patient risk should be allowed to go unresolved."*

3.2.33 Mediation and other forms of dispute resolution had played a part in successful outcomes for some staff. One contributor told us about a number of issues that had been satisfactorily resolved through informal local mediation. However some contributors told us how statements from mediation or 'without prejudice' meetings were used as a means of justifying disciplinary proceedings.

Feedback after raising concerns

3.2.34 Our surveys suggested that the majority of staff are told the outcome of any investigation into a concern they have raised but a significant minority are not. Some staff described how they had received either an inadequate response or no response at all to the concerns they had raised. Some indicated that organisations hid behind 'confidentiality' as a means to avoid feeding back on outcomes of investigations and resulting actions. This was linked to a more general view that there was a lack of transparency and openness about both the process of investigating concerns and the outcomes.

> *"As my concern related to personal performance it was not possible to share how the issue was being taken forward. How can staff be assured that this confidential process is indeed happening?"*

> *"A mechanism for feeding back to staff that raise concerns would be useful, indicating how they are going to investigate the complaint and giving some kind of timescale for resolution."*

3.2.35 Some staff did highlight that their organisations were making attempts to feedback more widely about concerns that had been received and action taken as a result.

Case Study: Value of responding to feedback

A trust employee said she thought her trust was good at listening to and resolving concerns. She explained that they ran a *'you said, we did'* campaign, which told staff what had happened as a result of the issues they had raised. This encouraged people to speak up and to feel that raising concerns was worthwhile. This public declaration of action that had been taken was seen as a positive development.

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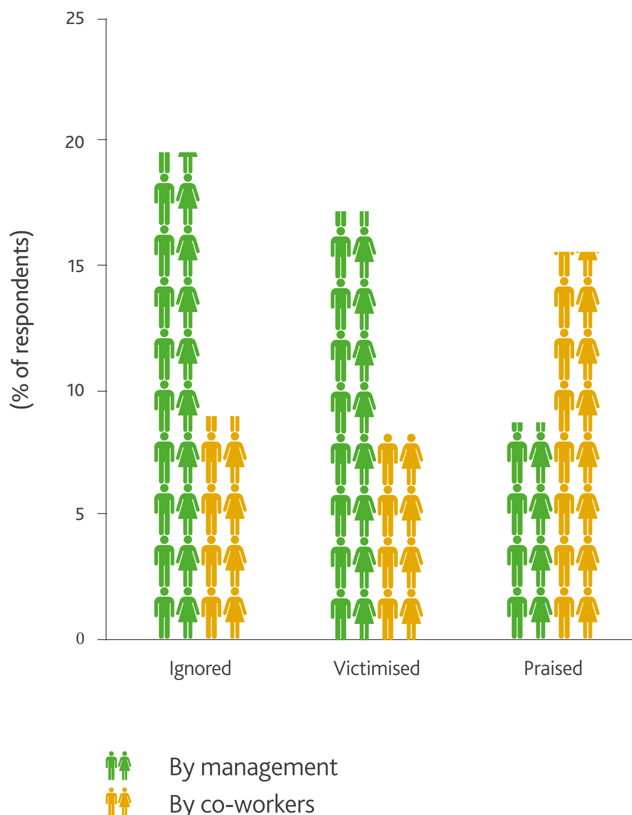
Detriment after raising concerns

> *"Whistleblowers are victimised and persecuted and find themselves being accused with false counter allegations, despite in most cases a lack of evidence of any wrong doing."*

3.2.36 Although the majority of trust staff responding to our survey did not report being victimised by management or colleagues after raising a concern, 1050 had experienced victimisation of some sort. This is too many. The survey also indicates that staff are more likely to be victimised or ignored by management after raising a concern than they are to be praised. Co-workers by contrast are more supportive.

Figure 3d – Reaction of management and co-workers to raising a concern
Source: Freedom to Speak Up staff survey



Case Study: A response to raising a concern in a trust

A nurse gave an example of raising concerns about the safety of patients and clinical care at a team meeting. She was called to an office and shouted at by two managers until reduced to tears.

She then described being criticised at every opportunity thereafter. She also noted that her appraisal was all criticism, no support and her mental health was questioned.

To her knowledge, none of the concerns she had raised were looked into and there was no feedback. She did not feel able to share details of the case elsewhere fearing a harmful effect on her career.

3.2.37 We heard of similar experiences in primary care settings.

Case Study: A response to raising concerns in primary care

A practice nurse described several incidences of raising concerns and being ignored by managers and made to feel a trouble maker. She described how she was then bullied to the extent she became unwell and had to take months off work to recover. Even now she suffers from anxiety.

She is now out of work and cannot find even a locum position. She believes she has been blacklisted. Her impression is that it does not pay to try to be a good nurse: you should just do what is asked without question.

The role of managers in handling concerns

3.2.38 There was much criticism of managers at different levels of the NHS structure, but particularly the way 'middle management' handles concerns. Amongst our contributors, staff rarely, if at all, seemed to believe that management dealt with or were able to deal with a disclosure in an

effective way. There were suggestions of: 'closing ranks'; collusion to protect NHS 'upper ranks'; deliberate manipulation by management; top management wrongly briefed; investigations turned against whistleblowers who were then scrutinised and subjected to disciplinary procedures; managers not taking responsibility for their actions; and, no sanctions for misuse of power.

> *"You are naïve to think this is about justice or patient safety […] [management] will take the easiest route to resolve a difficult situation and they see you as a troublemaker."*

> *"Rather than engaging meaningfully with me to explore my concerns and consider possible remedial actions or modifications to the system, there seemed to be a rigid defensive position that precluded any potential for change and denied any problem with the system."*

3.2.39 The overarching sense is that negative experiences have led to a distrust of managers, in addition to a more general mistrust of processes and concern that treatment of whistleblowers is biased and prejudicial. Few employees defended managers although a small number were positive about them.

> *"I have had a good experience as I report to the Director who is forward thinking, allows free thinking and encourages everyone's views and opinion."*

Confidentiality clauses

3.2.40 There appeared to be some confusion amongst employees about the impact of confidentiality clauses in settlement agreements. A number of contributors had felt pressurised by their employer to sign agreements containing such clauses and a small number indicated that there had been a threat of repercussions if they did not.

> *"There appears a clear strategy of closing ranks and putting the whistleblower under sometimes enormous pressure to leave or accept a compromise agreement."*

3.2.41 At the seminars there was an impression that confidentiality clauses prevent discussion, even of matters in the public interest, because of a belief that the employer might seek damages or the return of monies from a settlement. There was also confusion about when and to what the clauses applied.

Human Resources (HR), unions and universities

3.2.42 HR staff were criticised by some employees who shared their personal stories with us. There were concerns that HR did not provide sufficient support to individuals, tended to believe managers or were not adequately trained to deal with complex concerns.

> *"[There] is a danger that HR can just believe what the manager tells them, or believe what the employee tells them. And actually, they have a role in bringing objectivity, and asking some of the 'why' questions. Why has this person raised this concern? Why hasn't it been able to be dealt with by the manager? Why isn't the individual satisfied with the response? Why does the manager think that response is acceptable? Asking the 'why' questions in a very independent, objective way – and almost acting as mediator or translator, sometimes, between the employee and the manager…"*

> *"There has been unwillingness by HR to address the issues or give clear messages to the perpetrator that the behaviours were unacceptable. I feel that they just wanted to rid themselves of a problem rather than address it and the complainant becomes the problem."*

3.2.43 Unions received some criticism. There was an impression that unions were more likely to be on the side of management and the outcome of whistleblowing cases were too uncertain for unions to 'take on'. It was also suggested that unions are more comfortable focusing on pay, conditions and jobs rather than patient safety concerns and preferred to support 'easy exit routes' rather than challenge organisations about the concerns the employee had raised.

> *"By the time they get up to a senior person in the union, the whistleblowers are way, way down the line here, and their concern has been changed into an employment dispute."*

3.2.44 However, employees were not universally disparaging of unions.

> *"I had support from a [union] officer during the disciplinary and grievance and that was very helpful."*

3.2.45. There was some criticism of universities too, particularly in relation to student nurses. There were concerns that universities tend to take the side of the mentor rather than the student, that their processes are biased against the student and that they are not best equipped to consider fitness to practise cases.

Resolving Concerns

Moving on

3.2.46 Lack of accountability of managers and leaders appeared to impact on some individuals' personal resolution and ability to move on emotionally. This was especially the case when managers and leaders remained in post or went on to be promoted. A sense of injustice was apparent.

Getting back to work

3.2.47 Where a case had become difficult after the raising of a concern, staff were often not rehabilitated in the working environment, rarely redeployed within the organisation and sometimes dismissed. In some cases, staff decided to retire or, if they could get alternative employment, resign. There were some accusations of blacklisting within the NHS and examples of staff whose interviews or job offers had been withdrawn, often at very short notice.

> *"… very few continue to work in their field of expertise and even fewer manage to secure permanent posts. This is because of existence of blacklisting within the NHS. There is of course in addition gradual loss of skills once being unemployed. For many, the only option is to leave the country and look for work in other parts of the world."*

Views of organisations that represent whistleblowers

3.2.48 Organisations that support and represent whistleblowers reinforced and expanded on the issues identified above. Problems they highlighted included:

- a culture of fear
- victimisation after speaking up, for example intimidation and bullying and retaliatory referrals to professional bodies
- detriment after speaking up, for example professional, personal and financial well-being and, emotional and psychological detriment
- confusion over the definition of whistleblowing leading to misunderstandings about when a matter is whistleblowing, when the process starts and if an individual is protected
- concerns lost or 'contained' in middle management
- employers focused on the employment aspect rather than the patient safety issue
- lack of confidence in the investigation process. For example: restricting access to relevant documentation, tampering with evidence and

fabricating allegations, conflicts of interest of investigators, editing reports ahead of publication or blocking their disclosure
- lack of feedback to those who have raised concern giving the perception that nothing is done and/or matters go unresolved
- absence of a level playing field between employers and whistleblowers in terms of access to finance and/or legal advice
- staff let down or unsupported by the relevant union
- HR departments not supporting whistleblowers or preventing detriment to them
- loss to the NHS of highly skilled and experienced staff due to ill health, suspension or termination of employment after raising a concern
- informal blacklisting of staff
- individuals and employers not held accountable for bullying behaviour or making unfair or unfounded allegations against whistleblowers
- a general lack of leadership.

3.2.49 In addition these organisations noted the following issues:
- there should be a zero tolerance of bullying
- model whistleblowing policies can have unhelpful and regressive modifications
- there is a lack of understanding by employers of the legislation
- the legislation is not working as intended; it fails to protect those who make protected disclosures about patient safety concerns as it is retrospective
- professional regulators seem to struggle to hold clinical managers to account when they ignore or cause detriment to whistleblowers
- there have been positive changes in the experience of individuals where concerns have been raised with some regulators, specifically the CQC
- there should be regulation of managers
- there is little or no evidence of a favourable sea change – there is an over optimistic view of progress.

3.3 Employees from a black and minority ethnic (BME) background

Introduction

3.3.1 Much evidence relating to the experiences of BME staff in the NHS, such as the Royal College of Nursing (RCN) employee survey in 2013[57] and the Snowy White Peaks report[58], is not directly related to raising concerns. However, there was anecdotal evidence, including at a workshop I held with doctors from a BME background, that BME staff can feel particularly vulnerable if they raise a concern. It was suggested that they were disproportionately likely to suffer victimisation as a result. In particular we heard that BME doctors are:
- more likely to be referred to the GMC than non-BME doctors
- likely to receive more severe sanctions than non-BME doctors.

> *"My main area of concern is that the ethnic minority (BME) and the foreign trained NHS staff […] experience disproportionate detriment in response to speaking up against poor standards of care in the NHS."*

3.3.2 In view of these concerns our survey data was analysed to highlight any key differences between the responses from staff from a BME background compared to those from a white background (including non-British white staff). The survey findings that inform this section of the report are at Annex Dii.

BME staff in trusts

3.3.3 Around 10% of staff who responded to our trust survey were from a BME background. This excludes those reporting themselves as white non-British. The largest BME group reported being from an Asian or Asian British background, making up almost 5% of total respondents and about half of BME respondents.

57 *RCN Employment Survey 2013*, Royal College of Nursing, September 2013
58 *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*, Roger Kline, 2014

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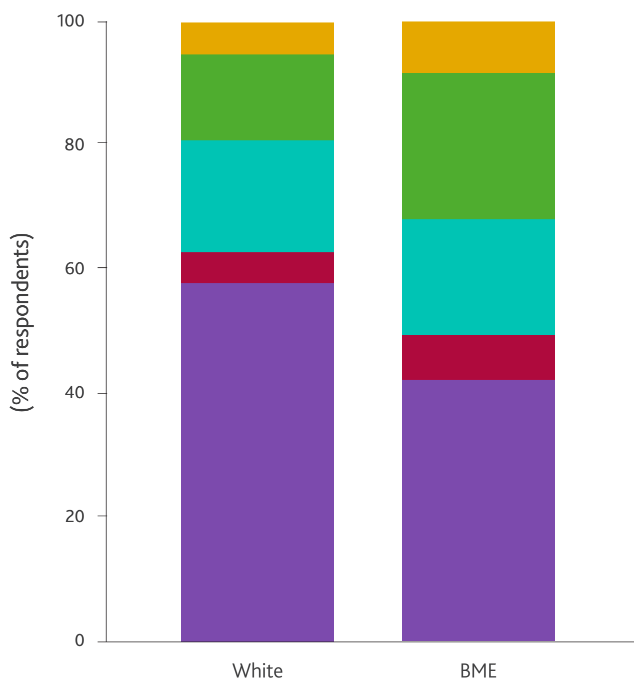
Reasons for not raising concerns

3.3.4 A higher proportion of BME respondents reported fear of victimisation as a reason for not raising a concern than those from a white background.

Figure 3e – Reasons for not raising a concern
Source: Freedom to Speak Up staff survey



3.3.5 A similar proportion of BME staff and staff from a white background first raise their concerns informally with their line manager. However, BME staff are more likely to have reported concerns about harassment and bullying than staff from a white background and appear to be less satisfied with the response to their concerns.

Case study: The perspective of a BME member of staff

A non-clinical member of staff from a BME background raised concerns about the approach taken by a senior director in awarding business to external contractors. After raising the concerns, a new manager was bought in to oversee this contributor's work and began to undermine them and closely monitor what were described as 'performance issues'.

The contributor hadn't previously experienced any problems at work and felt that they were being singled out for speaking up. They were treated differently to other members of staff. For example, the new manager was unwilling to make any concessions to allow them to observe important cultural customs. They felt they were being treated less favourably than their non-BME colleagues.

3.3.6 After raising a concern, BME staff were:

- more likely to report being victimised or ignored by management than staff from a white background
- slightly more likely to report being victimised by co-workers than staff from a white background
- less likely to report being praised by management than staff from a white background.

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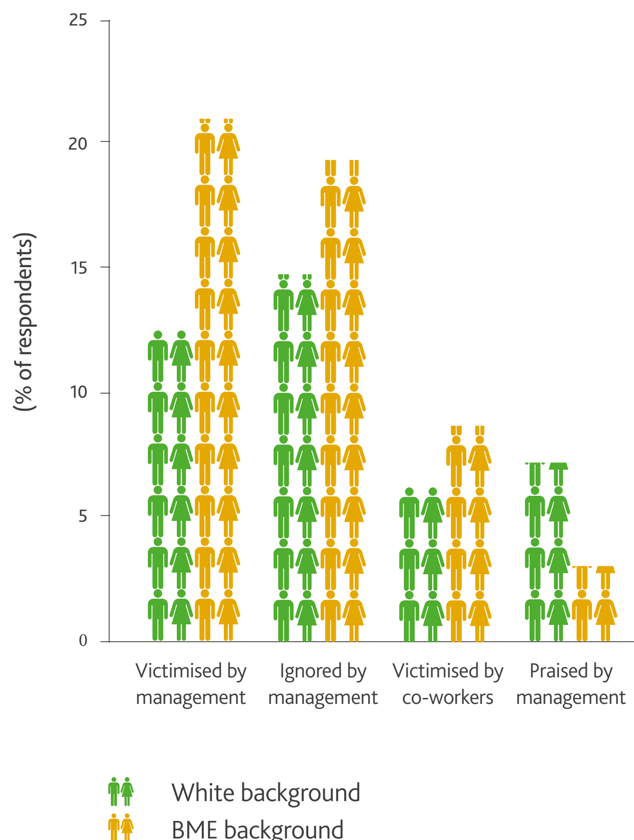
Figure 3f – Reaction of management and co-workers to BME staff raising a concern

Source: Freedom to Speak Up staff survey



> *"I've seen, and I know my colleagues have seen, a large pattern of South Asian origin doctor whistleblowers, because I think there's a different culture. There isn't that collegiate med school, we're all in this together, rugby team mentality that might exist a little bit more with UK educated doctors, although I may be showing my own prejudice here. Asian doctors – South Asian doctors in particular – can find themselves ostracised very quickly."*

3.3.7 In addition, after supporting a colleague who had raised a concern, BME staff were:

- more likely to report having suffered detriment than staff from a white background
- more likely to report having been victimised by management compared to staff from a white background
- more likely to report having been victimised by co-workers compared to staff from a white background.

3.3.8 BME staff reported being less likely to raise a concern again if they suspected wrongdoing than staff from a white background.

BME staff in primary care

3.3.9 A similar survey of staff in primary care (GP practices and community pharmacies) was carried out. About 24% of primary care staff who responded were from a BME background. This excludes those reporting themselves as white non-British. As for the trust survey, the largest BME group was from an Asian or Asian British background, making up about 16% of the total respondents and about two thirds of the BME respondents. The vast majority of respondents (almost 95%) worked in pharmacy.

Differences between responses from BME staff in trusts and primary care

3.3.10 The messages from BME staff in primary care were broadly in line with those from BME staff in trusts. However, trust staff from a BME background were considerably less satisfied with the response to their concern than staff from a white background whereas BME staff in primary care were broadly as satisfied as staff from a white background. The reason for this is not clear from the survey response.

Suggestions to improve the process and outcome of raising concerns for BME staff

3.3.11 Suggestions from BME staff to improve raising and handling concerns were in line with suggestions from other contributors such as:

- culture change
- clarification of the process
- a named contact in each organisation to act on concerns raised
- stronger leadership
- better accountability
- more transparency.

3.3.12 One BME specific suggestion was that CQC should consider as part of their inspection process issues such as:

- how many BME doctors are undergoing a disciplinary process
- how many BME doctors have excellence awards
- the outcome of incidents amongst BME patients alongside the outcome of concerns raised by BME staff.

3.4 Employers

Introduction

3.4.1 Employers and their representatives (referred to as employers in this chapter) highlighted examples of good practice to learn and build from in terms of raising and handling concerns and suggested the focus be on drawing attention to such examples and encouraging their spread across the NHS. They accepted that there was room to bring all up to the standard of the best. They favoured practical, rather than legal or regulatory, solutions.

Overarching issues

Culture

3.4.2 Evidence from the qualitative research indicated that employers fall into two groups when handling concerns:

- those who might be described as 'gatekeepers', who seek to maintain and emphasise the formal boundaries of what the law recognises as a protected disclosure resulting in a somewhat inflexible approach to what can be covered and how it can be addressed
- those who adopt a more flexible open-minded approach, experimenting with less rigid procedures aimed at increasing communication and engagement throughout the organisation.

> *"Leadership in the NHS is about receiving feedback day-in, day-out with a view to improve. It's the way we need to be, and many are."*

3.4.3 Employers recognised that a move from a blame culture to an open, transparent and learning culture was important and necessary and that culture starts at the top of an organisation. However, they noted that there could be very different cultures in different parts of an organisation. They agreed that raising concerns should be a normal part of the job for anyone working in the NHS.

"There is a unanimous view from employers that they want their staff to raise concerns, be curious, ask questions and shout up if they think patient safety is being compromised."

3.4.4 Employers recognise that there are a number of barriers that can still influence behaviour and prevent people speaking up such as: fear of being viewed as a troublemaker; fear of reprisals from colleagues and peers; and a lack of confidence that their employer will take their concern seriously. We heard how some trusts were taking action to address this.

Case study: Local action to change culture

A trust told us how they had used emerging themes from the Savile investigation, recommendations from the Francis Inquiry, staff survey results and routine monitoring to review and revise their approach to raising concerns. They established a programme of work to listen to staff and evaluate existing arrangements and, in partnership with Public Concern at Work, developed a new policy, framework and approach to reflect good practice. They plan to keep this under review.

3.4.5 Employers emphasised that culture change is not easy or quick to achieve, particularly in the NHS. There were references to the constant restructuring of the NHS and a strong message that it can be hard to embed culture change in an ever changing system.

"Everyone needs to stop restructuring the NHS… we never actually see anything through […] before you've actually embedded it, someone else has come along, there's been a new political party, and we're constantly restructuring."

3.4.6 There was also some concern that the Department of Health and regulators drive the NHS to focus on targets, performance and staffing levels rather than supporting staff and driving the right culture.

"Employers are under huge financial strain and there are currently 'flash points' between managers who are incentivised and frontline staff whose priority is quality concerns. This needs to change."

3.4.7 Employers did highlight examples of promising cultural change, although this was still in development. Some positive changes appeared to have been triggered by the CQC's new approach to inspection.

Role of Regulators

3.4.8 Some employers were concerned about fragmentation of the regulatory system and that system regulators duplicated information requests and were not clear about what constituted good practice in terms of volume and handling of staff concerns.

"The regulatory world has gone mad, tripping over themselves asking for the same information."

Raising Concerns

Encouraging concerns

3.4.9 A number of employers have introduced campaigns similar to the 'Stop the Line' initiative at the Virginia Mason Hospital in Seattle to encourage staff to raise concerns. This is described in more detail in 5.3.15

Anonymous concerns

3.4.10 Employers had mixed views on receiving anonymous concerns. Some said it was better that concerns were reported anonymously than not at all whilst others were concerned that it sent the wrong message to staff, that is to say that it was unsafe

to raise a concern. Some noted that anonymous concerns could allow them to consider if there was any substance in a claim without it being overshadowed by personality and integrity issues.

Raising concerns externally

3.4.11 Employers noted that concerns that had been raised externally to the organisation could bring benefits, such as stimulating a rethink of internal processes. They were, however, concerned about the use of the media to raise concerns. Many policies we considered expressly discouraged disclosures to the media. Employers stressed that inaccurate and/or disproportionate media reporting could be damaging to both the organisation and individuals involved. Issues could be misrepresented and they were not always able to give a full account in public to correct misunderstandings. Nothing contributed by employees suggested that this view was unjustified.

> *"It angers me when serious allegations are made which, in my view, are false and which the Trust cannot publicly answer other than in the most general terms."*

Handling Concerns

Complexity of Concerns

3.4.12 Employers felt that staff generally raised concerns out of a professional ethos. However there was concern about inappropriate use of whistleblowing by some employees, for example, to deflect away from performance issues.

> *"We must be able to separate out stories of aggrieved self-declared whistleblowers from the genuine cases more effectively."*

3.4.13 Employers stressed that cases were often complex where grievances, performance issues and whistleblowing were inter-linked. The responsibility of the NHS to protect whistleblowers needed to be balanced with the need to hold people to account who are not performing adequately.

Training

3.4.14 Some of the whistleblowing policies analysed for the Review contained no reference at all to training and some explicitly stating that no training was needed. Nevertheless we were told about initiatives which illustrate that a range of local training programmes are available.

> **Case study: Learning from local experience**
>
> A trust told us that after a high profile case some years ago they reviewed their policy on whistleblowing. The term 'whistleblowing' is now avoided; instead staff are asked to 'Be curious' and 'If in doubt, speak out'.
>
> Induction and training focuses on what the trust expects its staff to do, and how they will be supported. Anyone with a management role is trained on how to promote an engaging culture to support raising concerns. They have used conversations about the difficult case as a lever for discussions.

Use of processes and procedures

3.4.15 Employers indicated that whistleblowing procedures were often not used or were sidestepped by employees with concerns being raised externally, for example, with CQC.

Feedback

3.4.16 Employers were starting to realise that feedback practices were poorly established and that responding to concerns not only entailed considering appropriate action but also giving the person who raised the concern feedback.

How managers handle concerns

3.4.17 Employers acknowledged the concerns raised by employees in 3.2 about poor handling of concerns by 'middle management'. However, they stressed the pressure managers were under. For

example, they were under pressure from staff for them to resolve issues quickly and pressure from leaders to deliver targets within budgets. They are 'squeezed from both sides'. This might result in concerns being suppressed rather than escalated to senior management.

Bullying and victimisation

3.4.18 Employers were concerned about 'a false perception' that raising concerns always resulted in being victimised. Some were adamant that this was not the case and this perception was damaging to patient care deterring staff from raising concerns.

> *"The use of language is really important in building trust and confidence […] it is not helpful to frequently hear messages which say 'when staff raise concerns their careers are over' or 'they get sacked'."*

3.4.19 Most whistleblowing policies we analysed included a statement that those who raised a concern would not suffer detriment. They often stated that reprisals would not be tolerated, although about half made no mention of sanctions for reprisals. Employers agreed that staff should be protected from bullying and victimisation as a result of raising concerns. Whilst there is an indication that some trusts might have mechanisms to support this aspiration, evidence presented to the Review failed to provide comfort that those responsible for victimisation, even if numbers are small, are held to account (see 7.5).

Resolving Concerns

Closure

3.4.20 Employers were concerned that a small percentage of staff are, for whatever reason, 'chronically embittered' and would always be dissatisfied. Vexatious cases were highlighted as ones that could cause difficulties for organisations trying to improve culture. Some employers stressed that there needed to be an end point for cases, a means to reach a binding decision, respected by all, although there was scepticism about whether everyone would accept such a decision.

3.4.21 It was noted that providing a whistleblower with a response to their concern did not guarantee 'closure' for that person and they might still raise their concern elsewhere. Suggestions to help achieve closure included: giving the person who raised the concern a well-considered response; involving them in finding and implementing solutions; and making the response to a concern visible to all within the organisation.

Accountability

3.4.22 Employers acknowledged the desire from employees for accountability (see 3.2) but highlighted the need to distinguish between 'culpability and responsibility'. It was noted that a culture of blame and 'someone should be sacked' was not always helpful. Some whistleblowers may want 'instant retribution' but that that was not always within the power of the organisation to deliver.

3.5 Professional bodies (including Royal Colleges)

Introduction

3.5.1 The Review received written contributions from 11 Royal Colleges, including their umbrella organisation, and 5 clinical professional bodies. A number of these organisations also took part in our meetings and seminars.

3.5.2 There was a sense that staff raise concerns on a daily basis with their colleagues and managers and that these are resolved satisfactorily leading to better and safer care. It is when the process does not work and speaking up is discouraged that problems arise. There is a need for uniformity, consistency and fairness. The problems around raising concerns have been debated enough and the focus now needs to be on action. Processes are already in place for identifying, investigating and escalating concerns but they are not working well in practice. There is variability in how staff are treated after making a disclosure and whether the disclosure was acted on appropriately. Overall, concerns raised by staff should be given equal importance and respect to patient complaints.

Overarching issues

Culture

3.5.3 As with other groups of contributors, culture and the need for culture change was commonly referred to. Whether procedures and policies on speaking up were effective or not depended on the local culture. Processes would never be fully effective while the focus was on blaming rather than learning. A culture of openness and transparency was a prerequisite for the delivery of safe, high quality care. This was most likely in organisations that valued fairness, honesty, communication and trust. Speaking up was more likely by people in organisations perceived to be responsive to complaints and concerns.

3.5.4 Culture change is a challenge, particularly in large organisations. Commitment at board, senior management and senior clinical level is necessary to facilitate such change as is good leadership and a more open and supportive attitude by senior management. Culture can be dependent on external influences such as financial and performance demands placed on trusts. Possible conflict between meeting government targets and addressing staff concerns was given as an example.

> *"Ultimately, there needs to be a change in culture across the NHS which must start at the top. Significant pressure for positive results and good news stories from politicians and senior management often results in efforts to hide problems for fear of reprisals."*

3.5.5 The general view was that raising and addressing concerns needs to become normal practice. The NHS must normalise conversations about performance issues so that emerging quality and performance issues are routinely discussed before they become concerns. There needs to be a shared belief that raising concerns is positive, not a troublesome activity and that no detriment would occur.

Bullying

3.5.6 References to bullying were less common from this group although it was noted that a bullying culture is still perceived to be a problem and there should be no tolerance of bullying or undermining of staff. Some professional bodies are working together to address bullying. For example, the Royal College of Obstetricians and Gynaecologists (RCOG) is collaborating with the Royal College of Midwives (RCM) on a programme to address bullying and undermining in maternity services.

Raising Concerns

The role of professional bodies

3.5.7 A number of these bodies produce guidance for their members on how to raise concerns at work (see 2.6) and some have initiatives in this area.

3.5.8 The Royal Colleges can become aware of concerns through a range of formal and informal routes including surveys, invited service reviews and direct contact from members. Some were proactive in this area such as piloting 'regional conversations' to offer members and fellows a safe space to raise concerns or recruiting 'Workplace Behaviour Champions' for trainees who need independent advice about unacceptable behaviour they are experiencing.

3.5.9 A number of the Royal Colleges stressed that their role was to signpost individuals with concerns to the appropriate source of advice and support rather than act as investigators. Some were reluctant to play an increased role seeing this as the role of regulators, unions and educational bodies.

Students and trainees

3.5.10 Professional bodies stressed that healthcare students and trainees can provide important insights, bringing a fresh pair of eyes combined with experience gained through placements in multiple settings. They could be well placed to recognise instances of sub-standard care.

> *"Students, through their comprehensive exposure to different healthcare environments during training, have a particular capacity to identify problems within the health service, and to develop solutions."*

3.5.11 They noted, however, that students and trainees can feel intimidated by the hierarchy within a hospital and fear the consequences of speaking up thus making them reluctant to raise concerns.

Deterrents to Raising Concerns

3.5.12 Professional bodies highlighted a range of deterrents to raising concerns which were generally in line with those we heard from other groups. In addition, the Association of Surgeons in Training (ASiT) submitted the results of a survey[59] of surgical trainees to assess their experience in raising concerns about patient safety. The majority had had concerns over patient safety yet a significant number had not felt able to raise these concerns due to perceived barriers and a lack of confidence in the process. Problems highlighted included: fear of personal vilification or reprisal; fear of impact on career; lack of confidence in the process; hierarchy of the surgical profession; and no response/feedback or dissatisfied with response/investigation.

> *"When doctors feel that they will not be penalised for speaking up and that their actions will have a tangible impact then the NHS will benefit."*

Awareness of process and procedure

3.5.13 The need for a common understanding of how concerns should and should not be raised supported by clear procedures was highlighted. Clear processes and guidance were a common suggestion for improvement.

3.5.14 Some of this group thought processes were in place but not working well in practice, whilst others stated there was no clear system to enable the reporting and raising of concerns.

59 *Undermining and Bullying in Surgical Training*, The Association of Surgeons in Training, May 2013

Raising concerns anonymously

3.5.15 Staff having the opportunity to report incidents and concerns anonymously was supported.

Seeking advice about concerns/raising concerns

3.5.16 Initiatives and approaches that enable and sustain staff engagement were supported including processes to access the chief executive officer (CEO), medical director and trust non-executives such as at open meetings. Some contributors were attracted to the idea of a local champion-type role. Some saw value in a board lead to oversee internal processes for raising concerns, ensure staff feel empowered to raise concerns, and to ensure lessons from concerns are shared across the organisation.

Handling Concerns

Tackling concerns early

3.5.17 Professional bodies considered it was best to ensure problems did not arise in the first place rather than solely devise new arrangements for dealing with cases after the event.

> *"We believe that a situation in which a person working in the NHS feels their only option is to become a whistleblower demonstrates a failure on the part of the organisation to put effective reporting and investigation systems in place, and to manage this by providing adequate support to their staff to follow the steps in these processes."*

3.5.18 Open discussion and seeking joint resolution were considered the ideal but required a strongly supportive, non-threatening, management structure.

Complexity

3.5.19 Individual healthcare workers raise concerns for a wide variety of reasons. There is little reason to suppose that most are not genuine and represent a valid and justified exercise of the individual's professional duty to protect patients but sometimes reasons were questionable.

> *"There are occasions on which the mantle of "whistle-blower" can be adopted for reasons which are not completely honourable."*

3.5.20 Some whistleblowing cases could be complex. Dissatisfaction with the escalation or investigation process could become conflated with the original concern about patient safety turning into a costly and time consuming debate about people and process, rather than patients and their safety. Simplifying HR frameworks within which individual medical performance are managed was suggested.

> *"Cases are often not straightforward and can involve complex and long-standing professional and interpersonal difficulties between clinical colleagues. Cases can become a morass of claim and counter-claim with a toxic mixture of grievance and disciplinary activity where positions become quickly entrenched. Even if there is desire to resolve the issue, in many cases organisations may not have the expertise to do so."*

Detriment after Raising Concerns

3.5.21 Staff can be disadvantaged after raising concerns, for example, being told not to apply for promotion opportunities despite being qualified for them, themselves being accused of bullying and harassment, being suspended from work and having to defend themselves with little or no protection from their employer. Whistleblowing can also bring serious negative consequences for the individual including impact on mental health. Positively, however, the majority of surgical trainees who had raised concerns about patient safety responding to the ASiT survey (see 3.5.12) stated that this did not affect their career although a small number reported a negative experience ranging from feeling professionally isolated to having to move job or location.

3.5.22 The overall view was that there was still a way to go for staff to be treated fairly, with respect and in a way that protects them from being disadvantaged in their career after raising a concern.

Training

3.5.23 There may be a lack of expertise within organisations to resolve issues. Training and support for managers to understand their roles and responsibilities in the handling of, and responding to, concerns would be helpful. Senior clinicians can perceive criticism as a threat rather than an opportunity to improve ways of working and learning and become defensive. This could also be an area to cover in training.

3.5.24 Investment in high quality, joint training and leadership programmes for clinicians and managers to empower them to work in collaboration to respond in a timely, transparent and proportionate way to problems or concerns was needed. Other suggestions included: emphasising raising of concerns as a key principle of medical professionalism through education; embedding raising concerns within the annual appraisal and revalidation processes; and, training and guidance for HR departments in how to deal with staff who raise concerns as their support was variable.

Investigation

3.5.25 Objectivity and a full understanding of the facts of a situation and its background are key. Individuals close to a situation may form a particular view and any external assessment must take this into account. The truth can be elusive even with a fair, rigorous and comprehensive investigation of concerns.

3.5.26 Suggestions to improve the current process included: increasing clinical input into the 'assessment' stage of a concern; having a pool of trained internal investigators; use of independent mediation; and only suspending whistleblowers where there is evidence to show patient safety is endangered by not doing so. It was also noted that teams needed to support each other through difficulties and respond to problems in a timely and constructive way.

3.5.27 A number of the Royal Colleges referred to the Invited Review Mechanism they offer. These reviews are requested by organisations rather than individuals and generally relate to the performance of a particular unit or department. The resulting recommendations go to the trust management although issues of serious concern can be referred to the professional or system regulator.

Feedback

3.5.28 Feedback to staff after raising a concern was important. Management need to trust and respect clinicians and invest time in explaining decisions.

Support

3.5.29 Staff need practical or emotional support to navigate the steps in the process of raising concerns. The well-being of staff, both individually and as teams, needs to be considered. Partnership working between employers, trade unions and professional bodies should be promoted.

Managers

3.5.30 Managers need to strike a balance between providing a safe and excellent service to patients and working within tight budgets with financial cuts. The rapid turnover of managers can lead to the same problems recurring and staff not wanting to raise the same issues again and again. There was some suggestion that regulation of managers might be useful.

> *"The rapid turnover of managers in the NHS also works against investment, of both time and money, in long-term solutions."*

3.5.31 A number of professional bodies who wrote in to us signed an open letter to the Health Service Journal in December 2014 calling for a change in attitudes towards NHS managers.

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"In our experience, NHS managers are as dedicated to the service as any other group of staff. We find it regrettable, therefore, that they are so often the subject of ill-judged criticism and made scapegoats when concerns arise. This is both unfair and damaging to the interests of patients since successful joint working between managerial and clinical staff is an essential ingredient of good care."

Better data collection and analysis

3.5.32 This group was the most likely to refer to the need for better data collection, analysis and understanding to detect potential problems at an early stage and identify themes and trends that need to be addressed. The need to triangulate with other relevant information such as patient complaints and clinical outcomes data was noted as was the need to audit whether tangible action takes place. The need for regulators to actively seek information about staff concerns and culture was also raised.

3.5.33 Whilst the reporting of incidents and concerns had become easier and staff in many trusts are encouraged to report critical incidents and possible risks, it seemed that this was variable across organisations. It was suggested that more effective reporting systems were needed.

Resolving Concerns

Closure

3.5.34 There can come a point in some cases where the individual becomes 'fixated' on what has happened to them and may need personal support to move on emotionally. In such a situation there may need to be stronger action to encourage them to move on when all concerns have been investigated and exhausted to prevent both psychological damage to the individual and demoralisation of the wider team.

3.6 Regulators

Introduction

3.6.1 Eighteen system and professional regulators were sent a survey to find out about their role in advising on, and handling, staff concerns. The survey results are published at www.freedomtospeakup.org.uk and summarised at Annex Diii. There was sufficient information to make tentative observations but not to distinguish between responses from professional and system regulators. A number of system and professional regulators also wrote in to the review and/or attended our seminars to share their views. Some focused on the action they had, or were taking, to improve their own processes and guidance. Others offered views and evidence to inform further thinking.

Overarching issues

Culture

3.6.2 In line with a range of other contributors, professional regulators referred to issues related to culture including fear of being bullied or referred to professional regulators after raising concerns and factors such as divided loyalties and the 'bystander effect' that can be a deterrent to speaking up. System regulators also noted that negative connotations associated with the term 'whistleblowing' could act as a barrier to speaking up. One regulator noted that it gave a commitment that reports are used for local and national learning only and not for punitive actions so that healthcare professionals had no fear of repercussions from using their reporting systems.

3.6.3 As other contributors had done, regulators noted that some cases are complex with whistleblowing and human resource issues intertwined.

3.6.4 Some professional regulators stressed that patient safety depends upon a learning culture where errors and near misses are openly discussed and learnt from. However, absence of a blame culture may not be sufficient to encourage staff to

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be open about mistakes. Any attempt to change culture without a better understanding of the human and organisational behaviour factors that underpin it risks continued failure.

Consistent approach among regulators

3.6.5 A common understanding about what good looks like in terms of raising and handling concerns is needed so that regulators are consistent in their judgement about organisations on this issue.

Partnership working

3.6.6 The broader agenda related to raising concerns required partnership working by national and local organisations. One regulator stressed that all parts of the healthcare system (employers, professional bodies, unions, educators, commissioners, regulators, insurers and the legal system) needed to promote a common expectation that everyone who works in the system must:

- speak up without delay
- encourage and support a culture where anyone can raise concerns openly and safely
- listen to, respond appropriately to, and learn from any patient safety concerns
- hold to account anyone who mistreats someone because they have raised concern
- be held to account, by employer and regulator, if they fail to do any of this or mistreat someone because they have raised a concern.

Raising Concerns

3.6.7 Our survey of regulators indicated that the majority allowed concerns to be reported anonymously. The majority also sought to ensure the confidentiality of a named person raising a concern although most noted that this might not be possible in all circumstances.

3.6.8 Some professional regulators stressed that registrants have an individual ethical responsibility to raise concerns. However, managers and team leaders should encourage and support a culture where staff can raise concerns openly and without fear of reprisal. They noted that experiences of registrants raising concerns in the workplace were mixed, with some reporting poor experiences. Raising concerns to a professional regulator was seen as a last resort.

3.6.9 System regulators appeared to place great value on information from staff acknowledging that every concern provides them with vital information to help understand quality of care.

> *"It is absolutely priceless to have the whistleblowing information in terms of being able to target your time and energy. And also when we get whistleblowers it does say a thing about the trust and why these people are sharing information with us and they can't share with the trust. So, it is always important and useful to hear specifically from whistleblowers."*

3.6.10 Staff sometimes approach a regulator in an attempt to relieve themselves of the 'burden' of the concern. Regulators do not have the remit to resolve individual cases but sometimes staff feel that they have no one else to turn to. A regulator is not always the best body to help and this can leave its staff 'feeling relatively helpless' as well as leaving the person raising the concern frustrated. There could be an impact on both the whistleblower and on the staff of the regulator dealing with them.

> *"Some come to us because they're dissatisfied with the response they've had from the Trust. Some come to us because they don't have faith in their managers to address it robustly, and some come because they can raise concerns with us anonymously, and they feel more secure in doing that."*

3.6.11 Professional regulators noted that staff need to know how to report, what to report, or when to report. They need tools to challenge and raise concerns so that they did not progress to the extent that individuals felt compelled to blow the whistle.

Handling concerns

3.6.12 People should initially report concerns about suspected wrongdoing to their employer. One system regulator cautioned against any changes that might undermine the existing responsibility of providers in this area.

3.6.13 Professional regulators noted that whistleblowers should be supported and encouraged to be part of a solution, and not penalised or discriminated against. The need for collective reflection was also highlighted.

3.6.14 One system regulator noted that some concerns cannot be corroborated and suggested that the Review needed to strike a balance between encouraging an open reporting culture while ensuring that public money and time is appropriately spent. Another highlighted the need for coordination between regulatory bodies where the focus of concerns raised is difficult to identify.

3.6.15 The majority of regulators stated that they kept the person reporting the concern informed of progress of any investigation and some also noted that they publish the number of concerns raised with them, the number of investigations conducted as a result of concerns being raised and the outcome of investigations.

Resolving concerns

3.6.16 Regulators agreed with the view of employers (see 3.4) that giving a whistleblower a response to their concern did not guarantee 'closure' for that person.

3.7 Trade unions

Introduction

3.7.1 A number of trade unions wrote in to the Review and/or attended seminars and meetings to share their views. Some hold a dual role. Where this is the case their views have been included in the section on professional bodies (see 3.5.2).

3.7.2 The unions explained the difficult position they can be in. They can become involved in cases at a late stage and, if they do not pursue a case, the member can become disgruntled and see the union as their 'enemy'.

Overarching issues

Culture

3.7.3 As with other contributors, unions highlighted the need for a culture in the NHS that encourages staff to raise concerns. Organisations need to be receptive to staff, their views, opinions and concerns. Staff are deterred from raising concerns by a fear that they may be bullied or harassed. The NHS needs to move to a place where staff are confident to raise concerns in the knowledge that their manager and organisation welcomes this and sees it as an opportunity to improve the way care is provided.

> *"We want organisations to see staff raising concerns as golden nuggets of information, an opportunity to pause, listen, reflect and act."*

3.7.4 Unions suggested that some of the issues related to culture arose from the conflict between provision of care and 'balancing the books'. Individuals appointed to boards need a balance of business acumen and the softer skills needed to deal with people involved in a caring profession.

3.7.5 Changing the culture of the NHS is not an easy or quick option and requires sustained commitment and a change in both leadership style and recruitment.

Raising concerns

3.7.6 Unions highlighted some of the guidance and training available for members. Some of this is referred to later in the report. They noted that they are not prescribed persons (see 2.2) so staff do not have the protections afforded under the 1998 Act if they blow the whistle to a union.

3.7.7 Unions noted that there are a number of ways for staff to raise concerns, perhaps too many ways, leading to confusion about who best to go to and a blurring of responsibility about who should deal with the issues once raised.

3.7.8 One union stressed the need for significant tact when raising concerns and the need for recipients of concerns to show understanding. All staff need to be open to criticism of the care they provide and recognise the importance of not taking concerns personally and using feedback as an opportunity to consider how to improve the service or care provided. Training, communication and leadership would be needed to move forward. The need for good managers with strong listening and communication skills was highlighted, as was the need to cover whistleblowing policies at induction.

3.7.9 Boards must be a visible presence among hospital staff engaging them in a variety of ways in discussions to help build relationships and provide reassurance that they can be approached to discuss matters of concern. A designated board member, accountable for staff satisfaction and staff engagement, was thought to be beneficial. In addition, improvements were needed to local risk management systems and how the information collected is monitored and used in conjunction with other relevant data.

Handling concerns

3.7.10 Unions noted that 'objective truth' can sometimes be hard to find when investigating a concern. The importance of tracking the response to a concern and offering feedback, taking care not to breach any employment confidentiality issues for other staff involved, were also highlighted.

> *"A good comparison is when you shop on line you can track what is happening to your order and know when it will be delivered. The same does not apply in the NHS, where the information is entered on to the […] system, submitted and then staff hear no more."*

3.7.11 It was also suggested that PIDA did not provide adequate protection for staff who had blown the whistle as it can be difficult to show that detriment or dismissal is linked to a disclosure.

3.7.12 Ideas and suggestions to improve handling of concerns included:

- strengthening PIDA
- an independent body to investigate concerns where there has not been a satisfactory response
- at least one named contact within each organisation whose primary role it is to investigate and act on staff concerns.

Resolving Concerns

3.7.13 Employers seemed reluctant to settle whistleblowing cases due to the high level of media attention that they received and a fear that they would be portrayed as 'paying off' the claimant. This led to wasted resources, entrenched positions, damaged careers and failure to learn from and act on the concerns originally raised.

3.8 Other Sectors

Introduction

3.8.1 The Review team considered whistleblowing policies and practice in a number of sectors where safety is critical or where the role of whistleblowers is key: automotive, aviation, chemical and pharmaceutical, construction, financial, nuclear, oil/offshore, rail, retail and utilities. Publicly available policies from several leading companies based in the UK were considered and companies with, what appeared to be, successful or innovative policies were contacted for more information or invited to a meeting.

Whistleblowing policies

3.8.2 The small sample of whistleblowing/raising concerns policies considered were broadly similar. They typically consisted of a statement encouraging staff to raise concerns supplemented by open door policies, staff empowerment initiatives and/or standards on behaving ethically and honestly. There was also information on where to direct a concern, generally line management in the first instance, but if that was not successful or appropriate an independent phone line and/or dedicated website was usually offered.

> *"It must be as easy as possible for staff to report concerns."*

3.8.3 There appeared to be little information on the implementation of the policies available online; however some organisations recorded statistics on the number of reported incidents raised through their whistleblowing procedure.

Culture

3.8.4 All those we spoke to from other sectors confirmed that it takes a long time to get to a position where staff feel able to speak up. It requires concerted effort.

> *"It has been a long hard slog in the aviation industry, taking over 10 years to get to the position we are in today. This success is down to trust and trust alone."*

> *"It takes many years to bring in a safety culture, it could not be simply "dumped" on the NHS."*

3.8.5 Culture change comes from the top. People follow the example of leaders and this then filters down through management to front line staff.

> *"Culture is set by all staff but filters from those at the top. People copy the behaviour of their boss […]. Leaders have to walk the talk. What is said must be seen to be done."*

3.8.6 Organisations spoken to purport to have a 'just' culture rather than a no blame culture.

> *"We have a just culture, which is different to a no blame culture. Things beyond a certain point cannot be ignored and people understand this."*

3.8.7 Once this culture is in place it has to be properly maintained.

> *"…one wrong word could undermine years of work."*

Raising Concerns

Terminology

3.8.8 These sectors seem to refrain from using the term 'whistleblowing' in their policies, instead using terms such as 'speak up' or 'raise concerns'.

> *"Whistleblowing is a term that we keep away from, it is seen as dobbing someone in."*

Process

3.8.9 It needs to be as easy as possible for staff to raise concerns. A variety of mechanisms involving phone, text, email and paper based reporting, appeared to be available alongside speaking to a line manager and electronic reporting systems.

Incentivising the raising of concerns

3.8.10 Financial reward systems were not favoured. Rewards might encourage people to leave things to go wrong so they could claim a reward. A 'thank you' and being seen to take action on an issue were the best methods to satisfy staff.

> *" We have a safety conference every two years for staff from all levels of the business from cleaners to directors. We award prizes to staff for raising concerns and staff stand up and tell their stories – this is the most powerful bit."*

Handling Concerns

3.8.11 In terms of handling concerns it was suggested that:

- anonymous reporting is permitted but not encouraged as an identifiable report allows issues to be discussed in more detail

> *" I would be worried if all calls came anonymously and likewise I would be worried if there were no anonymous calls at all."*

- trained investigators make a real difference
- investigations should be undertaken separately from the local team

> *" If you don't investigate properly you can lose trust."*

- feedback is vital

> *"Staff are good at chasing up and challenging us when no feedback has been received."*

- dysfunctional relationships could be a safety issue: investigations should focus on safety with any HR issues dealt with separately if possible

> *"Our investigation process for safety concerns is completely separate to the normal HR disciplinary process."*

- staff should be supported after they have raised a concern, some organisations followed up staff a few months after raising a concern to ensure there had been no detriment for them
- leaders need the right skills.

> *"Recruitment of the right leaders with the right behaviours (and removing those who do not) is critical."*

3.8.12 The case study below demonstrates some of the actions NATS, the organisation responsible for air traffic control in the UK, has taken to create an open and just culture.

Case study: Promoting a safety culture

NATS is responsible for air traffic control in the UK. Safety is a key priority and over the last 10 years their commitment to a culture of safety has resulted in a significant improvement in safety performance and a significant reduction in the number of safety incidents.

Strategic Priorities:

People create safety
(personal capability and responsibility for safety)

Safety intelligence
(data and information)

Tailored and proportionate
(safety management system – is it fit for purpose)

Challenging and learning
(inc. supporting external organisations and helping them understand their accountabilities)

Raising concerns

- There are a number for ways staff can raise concerns:
  - internally and confidentially through the Safety Tracking and Reporting platform (STAR)
  - directly with line manager, the safety director or the chief legal advisor
  - externally and anonymously through the CHIRP reporting system
  - directly to the regulator (CAA).

Handling concerns

- Independent trained specialists are used to investigate
- staff are usually non-operational during this time, this is seen as standard practice
- the whole process is conducted quickly, usually in a matter of days
- feedback is provided to those who raised the concern and to all staff where appropriate.

Resolving concerns

- Basic errors are tolerated
- there is a scale of remedial action available following an investigation. This can range from retraining/ mentoring to demotion or, in rare circumstances, dismissal
- retraining can be offered to whole teams where wider issues are detected.
- crisis incident stress management (CISM) provides staff with someone to talk to who is independent of the investigation and the unit.appropriate.

A learning organisation

- Data is constantly used to measure improvements in safety – both leading and lagging indicators are used
- a safety conference is held every two years – it includes recognition of staff who have raised concerns and sharing of their experiences
- human factors experts (including psychologists and ergonomists) are used throughout the business (23 in an organisation of 4000 staff).

3.9 Other Countries

Introduction

3.9.1 The Review team considered whistleblowing policies and initiatives in other countries. Due to time constraints it was not possible to provide a comprehensive global picture. The team therefore focused on English speaking countries and some countries in Europe where information was readily available.

Background

3.9.2 Most western countries have legislation offering protection to whistleblowers. The UK is often seen as an exemplar on whistleblowing, both in terms of legislation and wider support. The 1998 Act, often referred to as PIDA, has been used as a template for laws in other countries.

> *"The United Kingdom indeed appears to be the model in this field of legislation as far as Europe is concerned. It was one of the first European states to legislate on the protection of whistle-blowers, its law was even described as 'the most far-reaching 'whistle-blower' law in the world."*[60]

3.9.3 Nearly all countries we considered offered some form of legal protection from retaliation after whistleblowing. However, this appeared to be viewed as inadequate or hard to use, as it can be here. We read that employees raising concerns still suffered problems at work including being sidelined or dismissed.

Portrayal of whistleblowers

3.9.4 The translation of whistleblowing into other languages provides a hint as to the public perception of whistleblowers. Some countries such as Denmark and Germany have adopted the English word for day to day use. In others, the translation has negative connotations, such as 'snitch', 'squealer', 'nest-soiler' or 'informer'. Some countries have a more neutral term. In The Netherlands, for example, they use a term that translates as 'bell-ringer'. Examples from other countries include 'alarm-setter', 'hint-giver' or 'reporter'. In Italy, Transparency International uses the phrase 'civic-sentinel' to portray whistleblowers in a positive light.

Action in other countries

3.9.5 Approaches to, and procedures for, whistleblowing in other countries that differ to those in England included:

- whistleblowers receiving a percentage of any money recovered from a fraud identified or fine levied (including in the healthcare sector) as a result of their whistleblowing [USA]
- a Joint Commission, an independent non-profit organisation, accrediting healthcare organisations. The accreditation is recognised as a symbol of quality that reflects an organisation's commitment to meeting certain performance standards including eradicating behaviours that undermine a culture of safety [USA]
- a Public Sector Integrity Commissioner, to investigate wrongdoing in the federal public sector and help protect whistleblowers from reprisal, referring their cases to a special 'Public Servants Disclosure Protection Tribunal' if reprisals are thought to have occurred. The tribunal can conduct hearings, encourage the use of and facilitate alternate dispute resolution and has the power to order remedies for whistleblowers [Canada]
- some nurses wear a badge that highlights that they are advocates for raising professional responsibility concerns [Canada]
- a Commonwealth Ombudsman responsible for promoting awareness and understanding of PIDA, monitoring and reporting on its operation to parliament, setting standards to which public agencies must comply, and receiving and investigating complaints about the handling of public interest disclosures by public agencies [Australia]

60 *The Protection of Whistleblowers, Doc. 12006*, Pieter Omtzigt, 14 September 2009

- an independent whistleblowing advice centre for staff in all sectors [The Netherlands]
- restrictions on anonymous reporting to whistleblowing hotlines [France]
- each employer having an internal reporting officer who can receive protected disclosures, employees required to report internally before externally, and whistleblowing legislation not protecting those who report anonymously [Malta].

4

Key themes from the evidence

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4 Introduction

4.1 There was a high level of engagement with the Review from a range of relevant groups. A wide divergence in perspective might have been expected between NHS staff who felt they had been badly treated on the one hand and managers and leaders who handle concerns on the other. In fact there was a remarkable degree of consensus about the nature of problems in the system and the solutions. There was some difference of emphasis. Employers were more concerned about cases where 'whistleblowing has been used as a lever by the disgruntled, the axe grinders and the campaigners'[61]. There were also different views about how much progress the NHS has already made to encourage people to speak up. Organisations representing employers emphasised that much had been done and things were improving, whilst those representing whistleblowers considered this to be over optimistic. However there was no suggestion that the system for raising concerns was working well universally, and everyone agreed there was room for significant improvement.

4.2 It was clear from all that we have heard that there is a gulf between the actual experience of staff raising concerns in the health service and the understanding of managers and leaders of that experience. Some delegates at the seminars were clearly taken aback by the extent of the hurt and distress experienced by some of the whistleblowers who contributed to the Review. In some cases these impressions led to a change in previous perceptions of whistleblowers and the problems they face. It is important to avoid the tendency, shared by at least some staff who blow the whistle and managers who have to handle the concerns raised, to default to polarised positions based on stereotypes rather than objective reality. Once such positions have been taken, it can be difficult, if not impossible, for them to be changed.

4.3 It is also important to keep this in context. Concerns are without doubt raised informally and formally on a daily basis as part of the day to day running of all healthcare organisations. These can range from concerns about a minor malfunction of a piece of equipment to systemic issues or wrongdoing such as fraud. They are heard, addressed and resolved.

> *"Every day in the NHS organisations clinicians will raise issues with their colleagues and managers and these will be resolved satisfactorily leading to better and safer care."*

4.4 In addition there is widespread recognition of the fact that staff are a valuable source of information about patient safety issues and an expressed willingness to encourage staff to speak up. Chapter 2 described some of the national initiatives in this area. We also heard from individual trusts and organisations about the steps they are taking to improve their own performance or spread best practice. Some examples are described in chapters 5-8.

4.5 Whilst this was encouraging, it was also evident from our research that progress from rhetoric to a shared good practice is at best patchy. There is still a long way to go. There was compelling evidence that:

- too many staff in the health service still feel unable or unwilling to raise concerns
- staff are deterred from speaking up by fear and by low expectations that anything will change if they do
- some staff who have the courage to raise concerns have bad experiences and suffer unjustifiable consequences as a result of doing so.

4.6 The experiences shared with us, and the stress and distress caused by them, have no place in any service which values, as the NHS must, its workforce and the profound contribution it makes to patient safety and care. This adversity is not confined to those who raise concerns. The ramifications, particularly when concerns are badly handled by an organisation, go much wider. They can impact on those about whom a concern may have been raised, colleagues, friends and family.

61 *Roy Lilley, The Speaking Out Summit,* NHS Managers.net, 8 May 2014

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From descriptions we heard, the personal cost to some individuals is shocking. People appear to have lost their health, their careers, their marriages, their homes and in some particularly tragic cases they had come close to losing, or had lost, their lives.

4.7 Whether or not it is possible in individual cases to attribute all or any of this directly to the raising of a concern, it is unacceptable. A service dedicated to the care of the sick and the promotion of public health owes a duty to those who commit themselves to these aims. They should care for and support them. The NHS has a moral obligation to do all it can to stop outcomes of this sort from happening.

4.8 There is also an impact on the organisation and wider NHS from the poor handling of concerns:

- when cases continue for years there is a cost for management, distracting their attention and energy from other responsibilities
- long term suspensions, court cases and settlements are costly for the NHS, as is the waste of skills when highly trained individuals are unable to find other jobs
- whole teams can be affected when there are difficulties, with divided loyalties, fear and uncertainty affecting morale and engagement.

Conclusion

4.9 I am satisfied from our evidence that the problems are real and there is an urgent need for system-wide action:

- **the level of engagement with the Review was high**. In addition to the 19764 responses to the online surveys, we received 612 written contributions from individuals and 43 from organisations, and we met over 300 people in meetings, workshops and seminars. Our researchers also conducted 37 in-depth interviews.
- **there was a similar pattern to many of the cases**. It was unnecessary to make a determination on the facts of each account to be satisfied, as I am, that they had a remarkable degree of consistency.
- **a significant proportion of the cases are current, or very recent**. This is not just about historic cases. It is not a problem that has gone away.
- **this is not just about a small number of high profile cases.** Over 1000 staff responding to our surveys said that they had been victimised after raising a concern.
- **there is a general perception that speaking up results in victimisation or lack of action**. Over 1600 of the staff who responded to our survey noted that they had not raised a concern because of fear they would be victimised and over 1800 did not trust the system. Whether adverse experiences are widespread or not, the 'expectation' seems widely shared and acts a deterrent to others.
- **student nurses and trainee doctors suggest the problem could be endemic**. They have experience of working in a number of organisations and gave consistent accounts of the problems and of variations in approach between individuals and organisations after they raise concerns.
- **evidence from other sources corroborates our findings**, such as the GMC trainee doctors' survey[62], the 2013 NHS staff survey[63], and a recent survey of 7000 doctors published in the BMJ Open[64].
- **initiatives to encourage people to speak up are numerous and widespread** indicating a laudable acknowledgement that the system needs to get better, and a commitment in well-led organisations to take the necessary steps to achieve this.
- **there is evidence of a bullying culture which suppresses concerns**. A reluctance to raise concern and reports of victimisation of whistleblowers were often associated with descriptions demonstrating a culture of bullying or perceived bullying behaviour.

62 *National Training Survey 2014: concerns about patient safety*, General Medical Council, November 2014
63 *NHS Staff Survey*, Picker Institute Europe, 2013
64 *The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey.* Bourne T el al.BMJ Open 2015

> The incidence of feeling victimised following whistleblowing – 20% […] will be a concern to those trying to build a culture in the NHS where it is safe to speak out[…] Given the large numbers involved, our study supports the view that whistleblowing in the NHS is not a safe action, that bullying is not uncommon and that these problems are not isolated events.[65]

4.10 From the evidence, the following themes emerged: the need for

- culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- extending legal protection.

4.11 These are summarised below and described further, with proposals on how to address them, in chapters 5-9. In addition, the evidence we collected provided a useful steer on what good practice looks like. This has also been summarised in chapters 5-9.

Culture change (see chapter 5)

4.12 Culture was one of the issues most commonly referred to:

- organisations need to create the **right culture**. There was evidence from the research that some, but by no means all, organisations are beginning to change their culture, but there is a long way to go. There were references to the need for a 'no blame' culture, but others suggested a **'just culture'**. More needs to be done to spread **good practice**
- raising concerns needs to become **the norm**. It is not yet the case that everyone considers it is the right thing to do and the safe thing to do
- too often cases turn into adversarial **employment issues** instead of focusing on the safety issue. This appears to be driven by one or more of a number of factors:
  - the legal protection is embedded in employment law: this encourages cases to be seen as raising issues about individuals and not about safety and systems
  - HR is often responsible for the policies and for the management of difficult cases where concerns are raised, not those in the organisation responsible for safety or service delivery
  - there is sometimes a failure to distinguish between grievances and whistleblowing
  - sometimes employers receive risk averse legal advice which recommends a cautious response instead of an open and honest conversation
  - middle management is sometimes responsible for **'containing'** issues rather than passing them up the chain
  - a serious concern amongst employers is the perceived use of whistleblowing to **deter or delay management of poor performance** or poor attendance.
- there is **confusion** about the meaning of the term 'whistleblowing', and also what protection is provided by the law
- there is variation in the **quality of policies** and procedures for handling whistleblowing
- **bullying** is a problem in the NHS. It takes a number of forms and it needs to be regarded as a safety issue. Those who bully must be held to account
- **visible leadership** is a necessary part of changing the culture. It is also a valuable way to keep in touch with what is going on but it is not universal practice
- people who raise concerns do not generally feel **valued** for doing so
- initiatives to encourage **reflective practice** as a means of exploring how things could be done better, and sharing issues and lessons learned bring benefits but this resource is being squeezed.

65 *The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey.* Bourne T el al.BMJ Open 2015

Improved handling of cases (see chapter 6)

4.13 Where cases are **handled well and quickly**, the likelihood of a good outcome for everyone was significantly higher. Too often we saw cases where a lot of distress for all concerned would have been avoided if they had been 'nipped in the bud':

- it should be possible for staff to raise **informal** as well as formal concerns
- formal concerns need to be **logged** and records shared with the person raising the concern
- there needs to be **greater clarity** and better communication with and **feedback** to the person who raised the concern
- **evidence is crucial.** The focus needs to be primarily on the safety issue, not on the motivation or sensitivity of the people involved;
- **investigations** to establish the facts need to be done quickly with a proportionate level of independence and expertise to help resolve issues and prevent escalation
- **anonymous** concerns are not ideal but can add value. It is better to have information anonymously about a genuine issue than not have it at all
- **mediation** and techniques such as alternative dispute resolution can have a positive impact particularly if used early on in a dispute. They should be used to address poor relationships within teams which can become safety issues
- **suspensions** should be a last resort. Too many people who raise concerns appear to be suspended or sent on special leave resulting in de-skilling and unacceptable personal consequences to health and well-being.

Measures to support good practice (see chapter 7)

4.14 The Review identified a number of things that need to change in order to support the culture and behavioural change required:

- there appears to be **little consistency** across NHS organisations about how to raise or handle concerns. This may cause difficulties for employees who move between organisations
- there is not enough face to face **training**, and there is variability in the content and quality – even the definition of whistleblowing can differ in training given. More training is needed for people raising, receiving and handling concerns, both in terms of procedure and support
- speaking up can require courage, particularly in work places which do not enjoy an open, patient centred culture. People who take that step need **support**, both before and after they have raised a concern. This support needs to be impartial, independent but influential
- help is needed for people who have been forced to leave their organisations after raising a concern but whose performance is sound who are looking for **alternative employment** in the NHS
- there is insufficient **transparency** in the way many organisations exercise their responsibilities in relation to the raising and handling of concerns
- there is confusion about the impact of **confidentiality clauses** in settlement agreements, and some evidence that they are unnecessarily restrictive
- there is a perception that those responsible for mistreating or mishandling those who speak up are never **held to account**
- the NHS is highly regulated but no-one has explicit **oversight** of whistleblowing. It was not always clear to whom someone should turn to help them resolve cases
- **system and professional regulators** have distinct roles in relation to governance and powers of inspection but there appears to be insufficient coordination and a gap in terms of support to individuals who raise concerns and holding people to account if they victimise or discriminate against them.

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Particular measures for vulnerable groups (see chapter 8)

4.15 There are some groups which appear to be particularly vulnerable to detriment if they raise a concern:

- **locums, agency and bank staff** are vulnerable due to the temporary or short term nature of their 'contracts' – they fear they will not be 're-hired' if they raise concerns
- students, especially **student nurses**, are vulnerable as they are dependent on their managers to pass their placements and worry that raising concerns will jeopardise this. Universities do not appear to always give them the support they need
- **BME staff** are vulnerable because they seem to be over-represented in referrals to professional regulators and may suffer harsher sanctions following fitness to practise hearings than non-BME clinicians
- **staff in primary care** are vulnerable because their organisations are generally small so they are easily identifiable if they raise a concern possibly putting their employment at risk. The demise of PCTs also leaves it unclear where they can go outside of their organisation if they have a concern.

Extending legal protection (see chapter 9)

4.16 It was noted that:

- there are omissions from the list of **prescribed persons** to whom public interest disclosures can be made and also some groups that are not covered by the protections offered by the Employment Rights Act 1996
- the law does not provide any protection or remedy for people seeking to find new employment.

What good practice looks like

4.17 There is widespread agreement about how the system for raising concerns should look and feel to staff when it works well. This is drawn out in chapters 5-9 and is brought together in Annex A.

4.18 The Parliamentary and Health Service Ombudsman (PHSO) and others designed a diagram to illustrate a user led vision for handling patient complaints. It clearly set out the outcomes that someone making a complaint should expect to see if it is handled properly. There are some striking similarities between the requirements of good practice in handling patient complaints and handling concerns raised by staff, in particular the impact both on safety and on the individual raising the issue. The PHSO's diagram has been adapted for this Review to apply to staff raising concerns (see figure 4a).

Figure 4a - A vision for raising concerns in the NHS

1 Identifying that something might be wrong

a. I know that it is right to speak up
b. My organisation is a supportive place to work
c. I am regularly asked for my views
d. I know how to raise concerns and have had training which explained what to do
e. I know that I will not be bullied, victimised or harassed as a result of speaking up

2 Raising a concern

a. My colleagues and managers are approachable and trained in how to receive concerns
b. My organisation has a clear and positive procedure in place
c. I know where to go for support and advice
d. Concerns are taken seriously and clear records are kept
e. Managers always explain what will happen and keep me informed

3 Examining the facts

a. An independent, fair and objective investigation into the facts will take place promptly and without the purpose of finding someone to blame
b. The investigation will be given the necessary resource and scope
c. I am confident that any recommendations made will be based on the facts and designed primarily to promote safety and learning
d. I will be kept informed of developments
e. The process will be kept separate from any disciplinary or performance management action

4 Outcomes and feedback

a. Where there are lessons to be learned they will be identified and acted on
b. I will be satisfied the outcome is fair and reasonable, even if I do not agree with it
c. I will be told what was found out and what action is being taken
d. A plan to monitor the situation will be put in place
e. I feel confident that patients are safe and that my team remains a supportive place to work

5 Reflecting and moving forward

a. I will be thanked for speaking up
b. I will speak up again in future if the need arises
c. I know that my concerns will be taken seriously and actioned as appropriate
d. Lessons learnt will be shared and acted on by me and my colleagues
e. I will advise and support others to speak up in future

5

Culture

5.1 Introduction

> *"Only if the good intentions of any law are matched by a change in culture can a safe alternative to silence be created[66]."*

5.1.1 There was near universal agreement that the most important factor affecting people's willingness to speak up or raise concerns is the culture of the organisation. Our research interviewees often made reference to NHS culture and this was reinforced in written contributions where most respondents identified organisational culture as a key factor in how whistleblowing is dealt with.

> *"…changing healthcare professionals' reactions to incidents from one of fear into an eagerness to report, explain and learn from what happened can only happen through cultural change."*

5.1.2 It was clear from talking to contributors that there can be very different cultures in different parts of the health system. For example, a Human Resources (HR) Director who had worked in an ambulance service and an acute hospital stated that the cultures were 'very, very different'.

5.1.3 There can also be various cultures within the same organisation. Different teams, different departments, and different hospital sites can all 'feel' different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command and control style with 'an individualistic dynamic and a blame culture'.

5.1.4 There was a general view, reinforced by meetings with other sectors, that:

- culture starts at the top of an organisation, and to some extent the wider NHS system. It then filters down through all levels of leadership and management to the front line point of contact with patients
- willingness to speak up is influenced not only by what is said by the leadership team, but also what they do and the signals they give
- culture change takes time and effort. It can take a number of years of consistent effort by the leadership of an organisation and engagement of staff to build the right environment. Constant vigilance is then needed to maintain this culture
- culture cannot and should not be imposed on an organisation from outside: any change programme needs to be owned and led by the leadership and staff of that organisation although this might require some help.

5.1.5 Our qualitative research identified some examples of promising cultural change, which we had also heard about from employers (see 3.4). It noted however that 'these pockets of learning were […] still developing, with new approaches being tried out'. Some of these changes had been externally triggered by the CQC's new approach to inspection. There also appeared to be much to learn from the experiences of other sectors.

Case study: New starter interviews

A non-health sector company holds one-to-one safety commitment interviews with new starters, including sub-contractors, to encourage a culture of care and mutual respect.

5.1.6 There is some disagreement about how far the system has already moved on the journey of culture change. Employers and their representatives are more optimistic about the progress that has been made than some representatives of whistleblowers.

> *"…caution is appropriate in drawing any evidence of a step change in culture and practice."*

5.1.7 Wherever the balance lies, it was very clear from the contributions sent to the Review, and from our meetings with junior doctors and student nurses, that there are still widespread problems. So whilst I am encouraged by the steps that are being taken and the progress that has been made in some areas, I am clear that there is still much that needs to be done. This is a

66 *Whistleblowing around the world: Law, Culture and Practice.* Guy Dehn and Richard Calland, IDASA (2004)

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problem that needs to be recognised and addressed at board level. There is no room for complacency.

5.2 A 'just' culture

5.2.1 There was widespread support in the evidence for a 'no blame' culture if we are to create an environment where staff feel safe to raise concerns.

> *"The emphasis is far too often on 'who can we blame' rather than 'what can we learn'. This leads to a feeling that individuals are used as scapegoats to deflect criticism from organisational failings which are frequently a major contributor to serious incidents."*

5.2.2 People need to be responsible and accountable for their actions, particularly where there is genuine wrongdoing or repeated errors.

> *"There has to be – not blame, but you have to take responsibility."*

5.2.3 It seems to me that this might apply equally to the manner in which concerns are expressed and the willingness to accept the good faith of those who try to respond reasonably to the concerns even if the conclusion is not what the person raising the concern would wish.

5.2.4 The aviation industry uses the concept of a 'just' culture rather than a no blame culture. A no blame culture is one where information is sought on the condition that blame will not be apportioned – mistakes are considered to be just that, mistakes. This is different to a just culture where people are encouraged to speak up about matters of safety or wrongdoing but know the difference between acceptable and unacceptable behaviour and actions and that beyond a certain point these things cannot be ignored. The key is that action is fair and proportionate. Workers in the aviation industry were encouraged to raise concerns but were initially reluctant to do so in case it led to delayed flights, even where passenger safety might be at risk. However, with consistent encouragement from managers and an emphasis on being fair and just rather than on blame, the culture shifted over a number of years.

5.2.5 The concept of a just culture was used in the 'Speaking Up' Charter (2012) (see 2.5.) It called on NHS leaders to work towards a just culture where staff are supported to raise concerns and are 'treated fairly, with empathy and consideration' both when they raise a concern and when they have been involved in an incident. The concept of a just culture is already in place in some parts of the NHS.

5.2.6 There were demands for greater accountability of managers and leaders, and for disciplinary action against people who are found to have bullied staff who have raised a concern. This is discussed further in section 7.5. There are circumstances in which accountability in the form of disciplinary action is essential, but we need to beware of the possible unintended consequence of worsening the blame culture for other staff.

> *"…reservations about the increasingly punitive culture faced by NHS leaders and the potential for this to lead to an increase in blame and avoidance, rather than openness. It risks also discouraging the high calibre leaders which the NHS needs."*

Conclusion

5.2.7 It is clear to me that the board or equivalent of every NHS organisation must take responsibility for driving and maintaining the necessary culture change, and monitoring progress.

5.2.8 The CQC should review these aspects of culture as part of their assessment of whether an organisation is safe and well-led. I think it is unlikely that an organisation which does not recognise the importance of instilling and maintaining this type of culture is one which is well-led. Likewise any department or unit, such as a ward, exhibiting such deficiencies is unlikely to be well-led.

5.2.9 The rest of this chapter sets out what I consider to be necessary to foster a culture of open and safe reporting of concerns. Some trusts will already do some or all of what is described. However it was clear from our evidence that many do not.

Good practice – Driving culture change

- Organisations:
  - explicitly recognise the importance of encouraging staff to speak up freely, and understand the contribution this makes to patient safety, through their actions as well as their words
  - agree a strategy to develop the right culture, which includes tackling factors such as bullying which might inhibit speaking up
  - devote time and attention to bring about this change, through board discussions, visible leadership and monitoring progress. This should include tracking progress on key indicators such as responses to the relevant questions in the NHS staff survey
  - demonstrate that those who speak up are valued and recognise their contribution to improving patient safety
  - provide time and resource so that all staff can engage in reflective practice.
- Boards review progress on driving and maintaining culture change at regular intervals.

Principle 1: Culture of safety

Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1 Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

Action 1.2 System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.

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5.3 Raising concerns – normalising

Introduction

5.3.1 The evidence in chapter 3 shows that raising concerns is often regarded as something 'risky' and to be avoided if at all possible. We need to get to the point where it is not considered exceptional, inappropriate, a matter of criticism or a matter for blame to raise concerns. It should be a natural and routine way to improve patient safety and develop learning.

> *"…staff are best placed to notice if something isn't good enough or below the standard we expect, so supporting them to speak out is vital to ensuring that poor practice is highlighted wherever and whenever it occurs."*

5.3.2 This is in line with findings of the Mid Staffordshire Public Inquiry[67] and other investigations into breakdown in quality of care such as the Bristol Royal Infirmary Inquiry[68] which highlighted the importance of staff feeling able to speak up. Staff who feel something is not right should feel confident to draw it to someone's attention. One company we spoke to tells its staff:

> *"If it feels wrong, it probably IS wrong."*

5.3.3 Speaking up is something that all staff need to do on a regular basis. In addition to the obligations with regard to incident reporting and the professional duty of candour, the introduction of the statutory duty of candour for organisations discussed in 2.3 means that all staff will need to ensure that their employer has the information with which to fulfil its obligations. More generally in order to ensure that patients are safe all staff need to feel free to raise concerns about the way in which they are treated, whether they perceive the cause to be due to systemic reasons, or to a deficiency in the performance or ability of one or more colleagues. All need to become accustomed to accepting that their own performance may be the subject of such comment and to be open to challenge.

5.3.4 Without a more receptive culture, these duties will put added pressure on professionals who feel a conflict between doing what is right and fears of the potential consequences for their career.

> *"The readiness of doctors to carry out their professional responsibilities by raising concerns has often been clouded by fear of the potential for personal and professional consequences."*

5.3.5 Key to this will be changing the mindset of everyone in the organisation from one of culpability and shame, to one in which people have sufficient self-confidence to admit vulnerability and fallibility, and to focus on the safety issue.

Standardisation of processes and policies

5.3.6 There was a degree of consensus between employers and staff that there would be merit in greater standardisation of processes and policies across the NHS, so that those who move between trusts, as many professionals in training do, would not be in any doubt about how to raise a concern. Common language, common policies, common processes and common expectations with regard to behaviour would facilitate this.

5.3.7 Our research highlighted a wide variation amongst policies, despite a model policy being available since 2003 and recently revised by the Whistleblowing Helpline, see 2.6. It also concluded that some policies did not contain good practice.

5.3.8 Problems included:

- very legalistic language
- vagueness or contradiction as to whom the policy was directed
- wrong or incomplete information, for example about regulators and advisory organisations
- mistaken or incomplete descriptions about confidentiality and anonymity.

67 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013
68 *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol*, Professor Ian Kennedy, 18 July 2001

5.3.9 Methods of registering concerns, monitoring and training were among the weak areas identified across the policies in the research sample. As the researchers noted, if policies are to drive behaviour and interactions within an organisation, it is important that they represent best practice. It is clear that there is scope for improvement in local policies.

Responsibility for the policy

5.3.10 Assuming whistleblower cases are employment issues instead of safety or quality issues hinders an acceptance of speaking up as a routine event. In many NHS organisations responsibility for the whistleblowing policy rests with Human Resources (HR) departments. This is partly because the legal remedy, for those who suffer a detriment either as a result of speaking up or as a result of being the subject of whistleblowing, is through employment law and partly because of a confusion between grievances and safety concerns.

5.3.11 Both grievances and processes to manage poor performance lead organisations to default into a risk management mode, focusing on the need to erect pre-emptive defences against possible claims. However, I believe that this in turn can lead to HR departments becoming involved in what should be regarded as safety concerns too early in the process, and a preoccupation with individuals rather than events. It is sometimes assumed that disputed concerns are raised by individuals to pre-empt or hinder some form of action against them. While this may be true in some cases, the original concern, which may be justified whatever the motive for it being raised, then tends to be ignored, overlooked or lost.

> *"...the most common response of too many employers towards staff who raise concerns which have not been addressed and who then seek to pursue them is to turn a patient safety/ care dispute into an employment dispute.[...] The original patient care and safety concern repeatedly gets "lost" as the employment dispute takes centre stage."*

5.3.12 I consider there to be a strong case for allocating responsibility for overseeing policy, procedure and practice in this area to the executive board member who has responsibility for safety and quality. This will ensure that the investigation of a concern and any consequent action is undertaken as a priority, and as a separate process from any employment processes and procedures.

> *"I repeatedly requested separation of employment (sickness absence) and whistleblowing responses. This has not happened. The same individuals manage both."*

5.3.13 Unless there are exceptional circumstances, no disciplinary action directly associated with the concern should be considered or taken until the completion of the investigation of the concern and identification of any required action. This does not preclude any action being taken in relation to an individual's performance that was already underway, or is unrelated to the issue raised, provided it is in line with the normal practice of the organisation and not undertaken in response to an individual raising a concern. This is considered further in 5.4.

Encouraging speaking up

5.3.14 Other sectors where safety takes priority have successfully made it 'normal' and acceptable to notify management about safety issues. It has often not been easy and required considerable effort and resource. However, with consistent encouragement from managers and a 'just' approach when mistakes were made, it was shown that the culture can be shifted over time to the point that raising safety concerns had been normalised.

5.3.15 In the US health sector, as in the UK, there has been much discussion about raising concerns and culture. An example often cited of where action was taken to address this is the 'Stop the Line' initiative at the Virginia Mason Hospital in Seattle which was based on an initiative developed at Toyota.

Case study: Stop the Line

Following the tragic and avoidable death of a patient at the Virginia Mason Hospital, Seattle, USA, the hospital management adopted a new approach to patient safety. Their organisational goal is now to 'Ensure the safety of their patients by eliminating avoidable death and injury.'

All staff (and indeed patients, friends, family members and visitors) are referred to as 'safety inspectors'. Everyone plays a part in contributing to the safety culture and the quality of care provided. One of the ways in which this is done is through empowering all safety inspectors to 'stop the line' when a potential mistake or error is spotted. This means that they can ask that a procedure is stopped to check that what is happening is safe and appropriate.

By ensuring that everyone feels safe to speak up, they hope to avoid patient harm and learn how to improve for the future.

5.3.16 In the UK the climate is undoubtedly changing. A number of trusts have introduced similar campaigns with slogans such as, 'If in doubt speak out' or 'Don't walk by'.

5.3.17 We also heard how some organisations were trying to get the message across to new staff as part of induction programmes.

Case study: Normalising through induction

New recruits to an organisation were told as part of their induction that it was an organisation which accepted that people made mistakes. What was important was that staff spoke up when mistakes or near misses occurred, so that they could be investigated, addressed and learning shared.

5.3.18 There have been several attempts to standardise and embed the process of raising concerns in the NHS. For example, the right to raise concerns and a commitment to encourage and support staff to speak up is already enshrined in the NHS Constitution[69]. There are also helplines, best practice guidance and model policies (see chapter 2). However, these have not succeeded in normalising the raising of concerns because 'normalisation' cannot be achieved by process and procedure alone. Process and procedure need to sit within a culture that inspires confidence that raising concerns will be dealt with in an appropriate way.

Fear of speaking up

5.3.19 People can be reluctant to speak up because of fear of being:

- blamed or made a scapegoat
- discriminated against
- disbelieved
- seen as disloyal
- seen as disrespectful in a hierarchical system
- bullied
- fear of wider consequences for a career.

5.3.20 Raising a concern can also be particularly intimidating for:

- students and trainees who are dependent on a placement being signed off
- junior staff working in hierarchical settings
- staff in close knit teams who might be afraid to 'rock the boat'.

> *"…many staff are still afraid of raising concerns for fear of upsetting colleagues, especially more senior ones."*

5.3.21 Organisations may also be 'afraid' to talk about the type of concerns being raised internally, just as previously they feared talking about patient complaints.

69 *NHS Constitution for England*, last updated August 2014

5.3.22 All of these issues need to be overcome. Normalising speaking up will contribute to achieving that.

The term 'whistleblowing'

5.3.23 I have considered whether the term 'whistleblowing' itself contributes to the barriers. I see three problems:

- there is confusion about what qualifies as whistleblowing. Some people consider whistleblowing to be about something concerned with criminal wrongdoing such as fraud rather than a patient safety concern. Some consider it applies when escalating a concern outside the normal management chain, or about a more senior colleague. Some believe it only applies when raising a concern outside the organisation, or even that it is limited to disclosure to the media or otherwise into the public domain
- the meaning of the term 'protected disclosure'. The complexity of the legislation and confusion among contributors about what constitutes a 'protected disclosure' is unhelpful
- the term has negative connotations, or can imply something separate from, and more serious than raising a concern as a normal activity.

5.3.24 I gave serious consideration to recommending that the term 'whistleblower' should be dropped, and some other term used instead. Although I still have reservations about the term, I have been persuaded that it is now so widely used, and in so many different contexts, that this would probably not succeed. Instead we should focus on giving it a more positive image. I believe that the measures recommended in this report will do much to promote the acceptance of 'whistleblowing' as normal and positive behaviour in healthcare.

Conclusion

5.3.25 NHS organisations need to have an integrated strategy to normalise the raising of concerns supported by an integrated policy and a common procedure for reporting incidents and raising concerns. I advise that NHS England, NHS TDA and Monitor should take joint responsibility for producing and cascading a standard policy and procedure taking into account the existing model policy developed by the Whistleblowing Helpline. This should not distinguish between reporting incidents and making protected disclosures, and should incorporate the good practice described in this report. NHS organisations may adapt the procedures to fit with local structures, provided they retain the principles and practice described in this report.

5.3.26 It is acceptable to suggest that staff raise concerns within their organisation before going to an external organisation. If there is a culture where it is safe and normal to speak up, this should not be a problem and is the most effective way of getting a concern addressed promptly. However staff should never be made to feel hesitant about raising an issue with a relevant authority outside of the organisation, such as the CQC, or to raise it anonymously if that is what they want to do. It is much better that a concern is brought to light in this way than for it not to be raised at all. Therefore policies must not be expressed, whether or not intentionally, so as to prevent or deter anyone from raising concerns directly with any prescribed person or any commissioner. They should also explicitly permit concerns to be raised anonymously (see 6.3).

5.3.27 A reluctance to raise a concern internally first, may indicate that there is some cultural barrier to taking that course. Insightful reflection on the causes for external referral of concerns should be a matter of routine, provided, of course, that this does not in itself promote a blame culture.

Good practice – Making the raising of concerns a normal activity

- When a staff concern is raised the primary focus is on identifying and resolving any patient safety issues.
- There is an integrated policy and a common procedure that does not distinguish between reporting incidents and raising concerns, and focuses on the safety issue not the possible legal status or other employment issues arising from the concern.
- The policy and procedure:
  - reflects good practice described in this report
  - applies to all staff concerns irrespective of whether the staff member classes it as whistleblowing
  - includes requirements necessary for compliance with any obligation to report issues to patients and the organisation such as professional and statutory duty of candour
  - authorises, and does not prevent or deter staff from raising concerns directly with any prescribed person, as well as any commissioner, but may advise them that the employer welcomes concerns being raised first within the organisation.
- The responsibility for overseeing policy, procedure and practice relating to raising concerns is allocated to the executive board member who has responsibility for safety and quality.
- Investigation of concerns is separate from employment procedures where possible.
- Disciplinary action necessary for any party associated with a concern is not considered or taken until the completion of any investigation and identification of any action required unless there are exceptional circumstances.
- Where a concern is reported to an external body, the organisation reflects, without seeking to blame, on the reasons why this happened.

Principle 2: Culture of raising concerns

Raising concerns should be part of the normal routine business of any well-led NHS organisation.

Action 2.1 Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.

Action 2.2 NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.

5.4 Managing poor performance and whistleblowing

5.4.1 The interaction between whistleblowing and management of poor performance is a complex and controversial issue. People who have raised concerns cite examples where they have suddenly been subject to critical appraisals and poor performance processes as a consequence of raising concerns which were taken as criticism. Students told us how their previous good record suddenly deteriorated, and some healthcare professionals described retaliatory referral to their professional regulator.

5.4.2 On the other hand, employers have expressed their frustration about weak performers who raise concerns as a deliberate attempt to thwart or delay the performance management process, by claiming that they have raised a protected disclosure which has to be investigated first. Their experience is backed up by other bodies, such as the National Clinical Assessment Service (NCAS), Royal Colleges, and professional regulators and at least one of the organisations that support whistleblowers agreed that it does happen.

> *"To date all potential whistleblowing incidents that I have been part of investigating were cynical attempts to distract attention away from a disciplinary concern around conduct or capability."*

5.4.3 Opinions differ on the extent of the problem. Whatever the scale, raising concerns for ulterior motives causes confusion and can result in unhelpful and unjustified suspicions about the authenticity of the concerns raised by all whistleblowers.

5.4.4 The motivation for a member of staff raising a concern has no automatic association with the truth or falsity of what is reported. Those who raise concerns should always be listened to: an expression of concern may well contain important safety issues. Just because someone is subject to poor performance or disciplinary action does not mean they are raising a concern mendaciously or with an ulterior personal motive. The concern itself must still be addressed as a matter of priority, and separately from any other issue involving the NHS worker who raised it.

5.4.5 The best way to meet the possibility of false allegations, dishonestly made, is to investigate and establish that they are false, and by separating this from any existing process in relation to the individual. If this approach is taken rigorously and fairly, there is no reason why the raising of a concern should ever impede the continuation of management of poor performance or disciplinary processes which are being undertaken for other genuine reasons. At the same time, this approach ensures that all concerns requiring action are identified, and that there is an evidence base justifying decisions taken about them.

5.4.6 This is not to suggest that deliberately raising a false allegation is ever acceptable. The impact of such conduct is huge. It:

- tarnishes the image of the vast majority of people who raise concerns for genuine reasons
- reinforces the negative perception of whistleblowers as 'troublemakers' setting back attempts to change the culture around raising concerns
- frustrates employers who become more wary and defensive in response to people who raise concerns, for example, focusing on the motive rather than the concern itself
- deters other staff from coming forward with concerns for fear they too will end up being performance managed.

5.4.7 Tackling poor performance is equally important. Poor performance is itself a safety issue, and NHS organisations must address it fairly and effectively.

> *"This is about the separating out of concerns about care malpractice or wrongdoing at work from personal grievance disputes. To me that's absolutely key to it, that's crucial."*

5.4.8 Managing poor performance in any sector is a complex and time consuming process. The fact that someone has made a protected disclosure does not preclude an employer from taking disciplinary or performance action against that person where this is appropriate. However, it would be completely wrong to instigate such action as a response to a concern being raised.

5.4.9 The design of a solution to this challenge has to start with meaningful and worthwhile performance discussions, appraisals and quality records of performance, absence etc. If there is a focus on developing staff capability in the first place, and on having the documentation and evidence to justify any performance action it should be possible to demonstrate that it is not in retaliation for speaking up. Managers need to have the confidence and capability to have honest conversations and to tackle poor behaviours where they occur, and not to succumb to the temptation to defer appropriate action because of potential difficulties. I do not underestimate how time consuming this can be, but delay in taking the appropriate action both in relation to concerns raised and performance issues can only make solutions more difficult to find. Continuous training for both new and experienced managers is essential to support this. I understand that Lord Rose has been considering the wider need for training for leaders and managers in the NHS and his recommendations should be relevant here.

5.5 Bullying

> *"…unless bullying is recognised as a fundamental obstacle to a healthy, learning, compassionate culture, progress will be limited."*

5.5.1 Chapter 3 gave examples of the many references to bullying we received in the written contributions, in the responses to our staff surveys, and in the discussions we had at meetings and seminars. Many of the people who shared their experiences talked about the routine bullying and harassment they have suffered within the NHS. It has been upsetting to hear people describe having been undermined, harassed and victimised and that, for some people, being on the receiving end of this kind of behaviour seems to mark a daily reality. Such behaviour should never be considered acceptable.

5.5.2 Bullying was raised with us in a number of contexts:

- staff raising concerns about persistent bullying behaviours
- attempts to cover up allegations of bullying
- fear of reporting bullying behaviours by senior managers
- bullying behaviour towards people who had raised a concern
- frustration that no one is ever held to account for bullying a whistleblower.

What is bullying?

5.5.3 It was clear from our seminars that there was a lack of common understanding of the term 'bullying'. This is a complex issue and it is important to understand what we mean by bullying.

Definition of bullying in the workplace by the Advisory, Conciliation and Arbitration Service (UK) (ACAS):

- Offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.
- Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.

5.5.4 Examples offered by ACAS of bullying or harassment include:
- spreading malicious rumours
- insulting someone by word or behaviour
- exclusion or victimisation
- unfair treatment
- overbearing supervision or other misuse of power or position
- making threats or comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing individuals progressing by intentionally blocking promotion or training opportunities.

5.5.5 Whilst there was agreement from all contributors we spoke to that staff should be protected from bullying, including as a result of raising concerns, it was noted by some that bullying is often 'in the eye of the beholder' and that the term could, on occasion, be misapplied.

5.5.6 Some employers and managers in particular registered concerns that firm management could be seen as bullying. It is clearly necessary for managers and colleagues to give staff instruction and set requirements and targets, and to disagree with them without that amounting to bullying. It is generally how these actions are carried out where problems can arise.

5.5.7 Many of those regarded as bullies by colleagues probably do not perceive themselves as such. They may consider their actions to be 'firm leadership', 'being decisive' or 'having a sense of humour'. Sometimes this may be a valid view but sometimes it may not. We all need to be mindful of how the way we speak and act is perceived by others. To an extent, whether people's experiences meet an objective standard definition of bullying or not is beside the point. If someone believes they have been bullied or harassed and the perception of others around them is that they have suffered or will also suffer in a similar way as a result of speaking up, then they will be less likely to raise a concern in future.

5.5.8 The perception of bullying can have the same detrimental effect as deliberate bullying conduct. The perception of a bullying culture has been a common feature of the system for too long. In the Mid Staffordshire Public Inquiry report[70] it was concluded about the Department of Health that: 'While there is not a culture of bullying within the DH, an unintended consequence of its directives and policy implementation has been that on occasions they have been perceived as bullying or have been applied oppressively. Reflection is required on how to avoid such a consequence'. It is time that such reflection occurred, not just in the Department of Health but throughout the NHS.

Why bullying is bad

5.5.9 The impact of bullying on individuals, on teams and on organisations as a whole are well known. Examples include:
- avoidable stress and resulting illness
- increase in sickness absence leading to stretched teams and/or increased spend on temporary staff
- poor morale and difficult staff relations
- loss of respect for managers and leaders
- difficulties in staff retention
- reputational damage
- patients suffering harm or receiving less than optimal care.

70 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013

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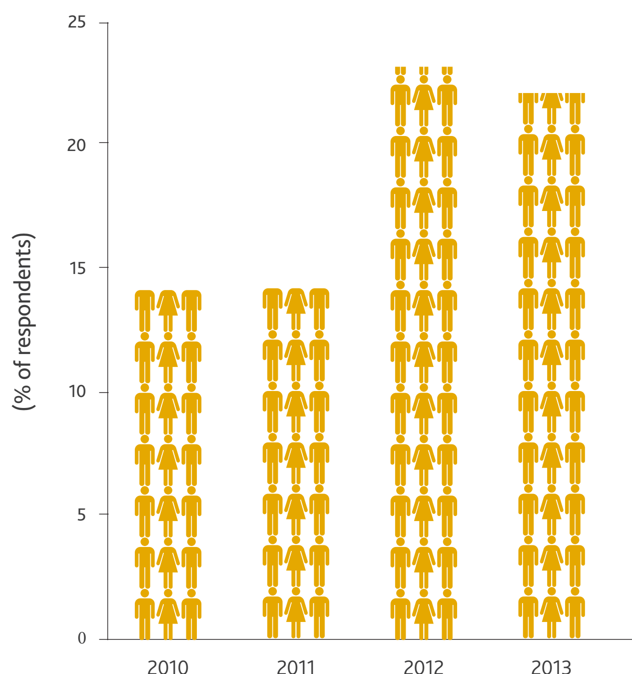
5.5.10 In the context of this Review the most important consequence is the fact that workers who are bullied, or who see others bullied, are much less likely to raise the safety concerns which any well-led organisation needs to know about and act on. Thus a junior member of staff who notices a potential error being made by a surgeon is far less likely to raise the issue in time to protect the patient if the surgeon is perceived to be a bully.

Evidence that bullying is a problem in the health service

> *"There exists a culture of bullying within the organisation that was largely covered up. For every case that comes to light, there is an iceberg of events that are simply not reported."*

Figure 5a – Staff experiencing bullying

Source: NHS Staff Surveys 2010, 2011, 2012 and 2013



Note: The wording of the question was not identical in each survey.

5.5.11 There is a range of evidence in addition to that received by the Review that indicates that bullying remains a problem within the health service. For example:

- the 2013 NHS Staff survey[71] revealed that just under a quarter of trust staff (22%) had experienced harassment, bullying or abuse from either their line manager or other colleagues. This proportion was, broadly, unchanged from 2012 (23%). Although the question was not identical, it appears to be an increase from 2011 and 2010 where 14% of trust staff reported experiencing harassment, bullying or abuse from staff in the last 12 months.
- the 2013 RCN employee survey[72] in which 30.5% of nurses said that they had personally experienced bullying or harassment from a team member or manager in the previous 12 months. There were 9,754 respondents to the survey.
- the 2014 GMC National Training Survey[73] in which 8% of 49,994 respondents reported experiencing bullying and 13.5% of 49,883 reported witnessing bullying.
- a survey of almost 8,000 doctors in the UK[74] about the impact of complaints procedures on their welfare, health and clinical practice showed that 20% felt victimised because they had been a whistleblower for clinical or managerial dysfunction.

5.5.12 The type of behaviour that those responding to the GMC National Training Survey had been exposed to included belittling or humiliation, threatening or insulting behaviour, deliberately preventing access to training and bullying related to a protected characteristic. The vast majority of staff identified by the GMC trainees as responsible for bullying behaviour towards them were registered healthcare professionals mainly consultants or general practitioners within the training post. Relatively few of these trainees reported bullying from management.

71 *NHS Staff Survey*, Picker Institute Europe, 2013
72 *RCN Employment Survey 2013*, Royal College of Nursing, September 2013
73 *National Training Survey 2014: bullying and undermining*, General Medical Council, November 2014
74 *The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK:* a cross-sectional survey, Bourne T. et al., BMJ *Open 2015'*

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> “ *It is clear that where a doctor in training is bullied or fears reprisals, they are much less likely to report any patient safety concerns that they have.”*[75]

5.5.13 In addition, Patients First noted in their contribution that, from the case review they carried out, bullying was reported to have occurred in 79% of the 70 cases they considered.

5.5.14 One view expressed to our researchers suggested a correlation between trusts with a bullying culture and those where people get ‘harmed’ when they raise a concern.

> “ *This isn’t just about whistleblowing, this is about if you disagree with me and I’m in a position of power, I’m going to treat you so badly that you leave, because it’s going to take me so long to use any HR process to get rid of you and prove you to be incompetent.”*

5.5.15 We saw evidence from one contributor of an attempt by a senior member of an NHS organisation to cover up information about bullying. This is totally unacceptable and everyone should be clear that such action will not be tolerated and will have consequences (see 7.5 on accountability).

5.5.16 We also heard about cases where management failed to take action despite repeated reports of bullying.

Case study: Impact of bullying

A junior doctor was bullied and verbally abused by a consultant. His predecessors had also been bullied and heavily criticised for mistakes. They had raised this with management but – to their knowledge – no action had been taken.

He raised his concern with the medical director, deanery, training programme director and training body on numerous occasions. Eventually he was invited to a meeting with the consultant and someone from HR. He hoped this would involve some sort of mediation to resolve the issue. Instead he was threatened and told that if he spoke to anyone outside the trust the consultant ‘would make sure he never worked again’.

The junior doctor considered resigning but is now working elsewhere as part of natural rotation. He is much happier, with his self-confidence restored but his confidence in trust management is severely dented.

Action to address bullying

5.5.17 A well-led organisation with a healthy culture is likely to have a range of good practice measures in place to prevent bullying – see good practice at 5.5.24. We heard examples of trusts being made aware of bullying on a particular ward and taking action to address it.

75 *National Training Survey 2014: bullying and undermining*, General Medical Council, November 2014

Case study: Action on local bullying

Members of a trust board received anonymous letters from a number of people working in the hospital's maternity service. No specific concerns related to patient safety were raised, but each letter alleged that some midwives were being treated less favourably than others and that offensive behaviour was rife in the department.

An attempt was made to resolve the issues at a local level, but staff in the division did not engage with the process established by the clinical director. The matter was then taken up by the trust executive management team, who implemented a three stage plan to try to understand and resolve the issues:

- listen to and engage with staff
- commission an external review of the problem
- implement change, where necessary, to improve the maternity services for all.

The investigation found no evidence that some midwives were being treated less favourably than others. However, a range of recommendations designed to improve the culture of the service were made. The findings were shared with the service and staff were content that the process had been conducted in a fair and open way and that the recommendations would help affect real change in the department.

Since making changes, results from the NHS Staff Survey have improved patient complaints have gone down and no further anonymous concerns from staff in this service have been raised.

A quarterly staff experience forum now monitors progress made in implementing the recommendations and acts as a safe place where people can voice concerns. Staff are allowed to attend in work hours.

5.5.18 There was also a recent example of a trust which asked ACAS to help them address a bullying culture that had been identified during a CQC inspection.

Case study: Action on a culture of bullying

A CQC inspection revealed a bullying culture which was supported by results from the NHS Staff Survey. The trust worked with ACAS to try to understand the problems and learn how to improve the organisation's culture.

A programme of staff engagement and evidence gathering was introduced. This indicated that employees felt victimised, undermined and frightened to speak up and there was a fear amongst some staff that this was leading to clinical mistakes going unreported. It appeared that the culture prevalent in the trust was having a range of negative effects.

The trust introduced a number of initiatives for change and ACAS made recommendations in areas such as strategic management, complaints handling, management of staff and communication and engagement.

Holding bullies to account

5.5.19 We heard from some contributors about action being taken against some individuals responsible for bullying but the numbers appeared to be small. The Department of Health was asked by the Public Accounts Committee in May 2014 if they were aware of action taken by NHS trusts and NHS foundation trusts against individuals proven to have bullied whistleblowers. They carried out a one-off survey to find out whether these trusts had taken any action against any manager or senior manager who may have bullied or harassed whistleblowers within their organisation from April 2011 to 31 March 2014. As it may be possible to identify staff from the data it is not in the public domain. However, the Department shared the results with us. The overarching messages are that:

- there are surprisingly few complaints about bullying and harassment formally recorded given the proportion of staff reporting these experiences in the NHS staff survey
- of cases that are recorded, about half go forward to an investigation stage
- where a case is found to answer, dismissal is very rare. Examples of sanctions that tend to be used include formal or informal discussions, verbal or written warnings, suspension, training action plans, counselling and mediation.

5.5.20 In line with the concept of a just culture described in 5.2, I think it is important that a systems approach is taken when bullying occurs. By that I mean that before embarking on the formal bullying procedures, steps should be taken to investigate the cause of someone's oppressive behaviour. This could be lack of awareness of their impact, which could be addressed through feedback and training; or there could be unacceptable pressures in their professional or personal environment, which it would be more productive to address through support rather than admonition. Failure to modify behaviour or repeated failings of this sort should however always be a matter for disciplinary action.

Case study: Looking out for the cause of bullying behaviour

A chief nurse makes regular visits to wards and spends time visiting patients and chatting to staff. She prioritised a ward that had received an increased number of patient complaints and a dip in the scores on the Friends and Family Test. Whilst there, nurses confided in her that they were worried about a nurse manager who was behaving in an 'oppressive' manner toward junior staff, verging on bullying.

She talked to the nurse manager, who admitted that she was experiencing considerable stress in both her professional and her personal life which was affecting her behaviour. She was given support but also made aware of the impact her behaviours had on her team.

Without disclosing any personal details about the case the Chief Nurse was able to feed back to the nurses that she had taken action.

Conclusion

5.5.21 I am in no doubt that bullying is a problem that urgently needs to be addressed. It has implications for patient safety, for staff morale, for performance, and for staff retention.

5.5.22 All leaders and managers in NHS organisations must make it clear through their actions as well as their words that bullying and oppressive behaviour is unacceptable and will not be tolerated. They should be constantly alert, and ensure that steps are taken to change it. Everyone needs to develop self-awareness about their own behaviour and its effect on others. Healthcare provision is almost invariably a matter of teamwork, and while individual skills are important and to be valued, it is totally unacceptable for colleagues to oppress others and hinder them deploying their own skills.

5.5.23 Boards should make it a priority to ensure that everyone in senior or managerial positions is aware of the importance they attach to eradicating any form of bullying.

5.5.24 Everyone in leadership and managerial positions should be given regular training on how to address and how to prevent bullying. This should include awareness of personal impact and the potential to be perceived by others as oppressive or bullying as described at 7.1.

Good practice – Promoting a no bullying culture

- Boards ensure that everyone in senior or managerial positions are aware of the importance they attach to eradicating any form of bullying.
- Employers take steps to ensure there is no culture of bullying in the whole of, or individual parts of their organisation. This includes:
  - Clearly articulated standards and expectations of staff at all levels:
  - developing strategies to work with staff to address bullying where there is evidence that there is a problem
  - regular training for everyone in leadership and managerial positions on how to address and how to prevent bullying including awareness of personal impact and the potential to be perceived by others as oppressive or bullying (see good practice in 7.1)
  - clarity in all relevant policies and procedures that bullying and harassment will not be tolerated, and that conduct of this nature is capable of being regarded as gross misconduct
  - a range of resources and support to address unacceptable behaviour, for example counselling and mediation
  - monitoring all relevant indicators and formal and informal reports of concerns to understand the culture in the organisation
  - fair procedures for dealing promptly with complaints and concerns about bullying.
- Leaders and managers:
  - are clear through their actions as well as their words that bullying and oppressive behaviour is unacceptable and will not be tolerated
  - provide constructive and honest feedback when they see inappropriate behaviour.
- Staff develop self awareness about their own behaviour and its effect on others (see good practice in 7.1).

Principle 3: Culture free from bullying

Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

Action 3.1 Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.

Action 3.2 Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.

Action 3.3 Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

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5.6 Visible and accessible leaders

5.6.1 Leadership is undoubtedly the key to creating the right culture within an organisation as a whole and the different levels within it. Lord Rose will shortly be publishing his review of leadership in the NHS. I have not sought to duplicate his work. However, it was very clear from the evidence we received that visible leadership in particular is of crucial importance to how staff feel about raising concerns.

5.6.2 Our qualitative research suggested that the NHS has valued a particular type of leadership that has been focused on delivery and achievements. It was noted that the behaviours of these leaders were target focused.

> *"…get the task done, let's tick the box, let's make sure we're meeting all those targets so that we're not subject to some kind of regulatory performance management or any scrutiny…"*

5.6.3 There seemed a general view that this style of leadership was not conducive to an open, honest and transparent culture. It was stressed that there was a need for more values-based leadership, visible and accessible to staff. People told us that there was no substitute for leaders 'walking the floor'. One organisation went so far as to suggest that 'a duty to listen' might be helpful.

5.6.4 This message was reinforced by chief executives (CEOs) and other leaders. We heard several times how they often find out what people are really thinking and feeling when they have informal face to face contact with them. We were given a number of examples of this informal contact.

Case study: Accessible leaders

A CEO spends a day a month working alongside a junior member of staff in different roles in the trust, wearing the same uniform and sitting with them in breaks. He finds that very quickly staff forget his position and are very open with him. This enables him to get a feel for the morale of that department or professional group. He regards this as a vital piece of feedback about the climate and culture of the organisation. It is also an opportunity for staff to raise specific issues with him, and to establish his reputation as someone who is approachable and interested.

Case study: Approachable leaders

A junior member of staff emailed a CEO about a concern. The CEO immediately responded in a personal email, and went to talk to the staff member. The staff member was initially taken aback, and slightly inhibited, but then opened up and commented that the CEO was 'really normal' and easy to talk to. This helped to promote the CEO's reputation as someone who was approachable and willing to listen.

5.6.5 Other examples of how leaders seek to be more accessible to their staff were described to us:

- regular drop-in sessions where staff can meet members of executive teams to discuss any issue – some also had a feedback loop to report on the action taken
- encouraging staff to flag concerns directly to their chief executive using a range of different communication methods including 'Dear John' and 'Tell Joe' initiatives
- CEOs and board members reporting in their bulletins to all staff or via tweets what they have learnt from spending time with different teams and going out with them on visits
- a CEO contracts with the team: 'you tell me and I will listen'.

Case study: Improving staff engagement

One trust has taken a number of positive steps to improve staff engagement and develop an open culture where staff are able to raise concerns in a variety of ways. For example:

- monthly drop-in sessions held by the Director of Operations around the county
- all staff invited to focus groups to talk about the top four issues raised from the last year's staff survey
- staff representation within the 'safer staffing' working group
- CEO spending time with different teams and reporting on it in their weekly bulletin to all staff
- staff representative officers having regular meetings with the CEO, Director of Operations and HR Director to raise and discuss concerns.

5.6.6 Regular contact between leaders and staff is important for three main reasons:

- it provides a source of information about patient safety – if staff raise concerns informally with leaders it can be dealt with swiftly and any growing tension or disquiet 'nipped in the bud'
- it provides a channel for feedback to staff about the concerns they have raised
- it actively demonstrates that leaders see staff concerns as a vital source of information about patient safety – this helps to normalise it and promote a no-blame or 'just' culture.

Leadership skills

5.6.7 A number of contributors noted that it was not enough for leaders to be accessible and visible. They also needed to have the right skills for leadership roles. This related not just to managers moving up the leadership ladder but also clinicians moving into leadership roles. It is vital that everyone who is recruited to a leadership role should be recruited for their leadership skills and values and should be given training and development to develop them further.

> *"There comes a point for every budding leader when […] attention to job-skills development needs complementing with attention to who and how they are as a human being: they need to know what it is like to be on the receiving end of their leadership, […], what people are likely to be saying about them in the canteen. They need to optimise the possibilities of every conversation they have. How well do they listen? How noticeable is their empathy? […] Development of this human dimension is crucial […]"*

5.6.8 It is equally important that behaviours and practice should be taken into account when recruiting staff or appointing them to leadership roles. A number of trusts told us that they now recruit for values as well as clinical competence. This should be the norm for all appointments, and is essential for appointments to senior roles. We heard too many examples of people taking on leadership roles without the right skills or appropriate training. I understand that Lord Rose's report will address these issues. I am also aware of Health Education England's National Values Based Recruitment Framework[76] which is intended to transform the way that students are recruited and trained so that they share the values set out in the NHS Constitution.

Conclusion

5.6.9 Many trusts and leadership teams will already have initiatives or practices of the sort described in this section as part of their leadership and engagement strategy. However, our independent qualitative research suggested that it is not yet universal.

76 *National VBR Framework*, Health Education England, October 2014

Case study: Unknown leaders

An executive director ran a seminar on leadership for junior doctors. He was startled to discover from the blank faces whenever he referred to the CEO by name that most of the junior doctors did not know who he was talking about.

5.6.10 Our research also indicated that some trusts want to change, but are not sure how to go about it, and are keen to hear about good practice that has worked in other trusts. I therefore welcome the work the Chief Nursing Officer has commissioned from NHS Employers. The proposed 'Draw the line' campaign shares good practice and I urge NHS organisations to take full advantage of it.

5.6.11 Visible leadership is essential as a means of creating the right culture and as a means to get valuable information about culture and patient safety from staff. Such visible leadership should not be confined to executive directors. All those in leadership or management positions have a responsibility to set the tone in their departments, to be open to ideas, share learning and to support those who wish to raise concerns.

Principle 4: Culture of visible leadership

All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

Action 4.1 Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.

5.7 Recognising and valuing staff who raise concerns

5.7.1 Culture and behaviour in an organisation is influenced by the signals the leadership sends about what it values. Public recognition of the benefits and value of raising concerns will send a clear message that:

- it is safe to speak up
- action will be taken
- people should speak up in future
- managers encourage speaking up.

5.7.2 We heard examples of how this is being done:

- posting notices summarising improvements that have been made as a result of concerns/issues raised by staff
- articles for in-house magazines to demonstrate how a concern had been raised, how it had been handled and how the learning had been shared
- inviting people whose concerns have resulted in improvements to patient safety to talk to the board about their experience
- a non-health sector organisation holds a biennial safety conference which includes a celebration of staff who have raised concerns. Some are invited to share their experiences with delegates
- integrating examples of raising concerns into recruitment, induction and appraisal processes to send a clear signal that speaking up is a positive behaviour
- a chief executive of a non-health sector company was regularly given a list of all staff who had raised a concern and phoned a sample to thank them personally.

Financial Rewards

5.7.3 I considered whether it would be appropriate to encourage financial rewards for whistleblowing. This is an incentive used in the USA, particularly in the financial sector.

5.7.4 I found no appetite for the use of financial rewards to incentivise the raising of concerns in this country. We were told very clearly that such rewards would not increase the likelihood that people would speak up. In fact, some individuals thought that financial rewards might cause resentment if some received them and not others. They suggested that this would not be conducive to good team working.

5.7.5 Interestingly none of the representatives from other sectors that we met offered financial rewards to staff who raised concerns. One suggested that an unintended consequence might be that staff delayed raising a minor concern, instead waiting until it escalated to a point that might be eligible for a financial reward or a bigger financial reward. Research undertaken by the Financial Conduct Authority (FCA)[77] showed that the introduction of financial incentives for whistleblowers would be unlikely to increase the number of quality disclosures made to them. The general message was that staff wanted better protection for all whistleblowers rather than financial rewards for a few.

Conclusion

5.7.6 It was made very clear to me by contributors to whom I spoke that what staff who raise concerns are seeking is recognition that they did the right thing and to see action taken to address their concern where it is substantiated. I do not believe it is either necessary or desirable to introduce financial rewards.

5.7.7 As part of the process of developing the right culture, I would encourage boards to send a clear signal that they value the contribution speaking up makes to patient safety through public recognition.

77 *Financial Incentives for Whistleblowers*, Financial Conduct Authority and Prudential Regulation Authority, July 2014

Principle 5: Culture of valuing staff

Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

Action 5.1 Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.

5.8 Reflective practice

5.8.1 The demands and pressures placed on staff working in the NHS can be enormous and there is no doubt that it can be stressful. The emotional turmoil caused when things go wrong in patient care and the impact this can have on an individual and the team in which they work is well documented. Coping with the pressure of continuous change adds to the burden.

5.8.2 Opportunities to discuss issues that are causing concern, why incidents occurred and how to prevent recurrences, and to share experience and learning are an important part of patient safety. They also play a key role in 'normalising' speaking up in a blame free environment, and providing mutual support to staff.

5.8.3 Our evidence indicates that:

- where staff are given the time to think about what they do and how they do it, they often find ways to improve processes, behaviours and relationships
- where organisations give staff time and support to engage in reflective practice they see improvements in morale, engagement and patient safety and experience
- multi-disciplinary reflection provides a valuable opportunity to break down professional silos
- reflective meetings provide a valuable opportunity for student nurses, trainee doctors and medical students who move around frequently between NHS organisations to share learning and good practice across the NHS.

5.8.4 There are already many examples of reflective practice being used in the NHS.

Case study: Schwartz Rounds[78]

Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across an organisation to reflect on the emotional aspects of their work. In its response to the second report into failings at the Mid Staffordshire NHS Foundation Trust, the Department of Health announced a £650,000 grant to the Point of Care Foundation to expand their work on piloting Schwartz Rounds in NHS Hospitals. Around 100 health and care organisations in the UK are currently contracted to run these Schwartz Rounds.

The Rounds give staff the opportunity to come to terms with the emotional response to difficult situations and allow staff to provide and receive reassurance and support helping to reduce stress and people's anxieties about the work they do and the problems that can occur. Everyone's view has parity in the round so they can help to breakdown professional 'silos'.

The Rounds mirror the environment and behaviours required to create an open and honest culture and there is increasing evidence that they are effective in increasing people's willingness to confront sensitive issues and in improving the non-clinical aspects of care.

78 www.pointofcarefoundation.org.uk/schwartz-rounds/

Case study: Mortality and Morbidity (M&M) meetings

M&M meetings are an opportunity for staff to have regular discussions on patient deaths, morbidity outcomes and, increasingly, near miss incidents. Those involved in deaths and near misses can talk openly about what went wrong and share their ideas on what changes can be made to ensure it does not happen again.

M&M meetings:

- help foster a supportive culture where mistakes are acknowledged and learnt from
- can be a catalyst for culture change.

5.8.5 We have also heard examples of local initiatives where staff are supported to share their feelings and contribute to improving services.

Case study: The Onion

Every morning at 08:15 a trust holds an open session in which anyone can raise any issue of concern. They ask the same two questions every day:

- are there any issues of patient safety?
- what can we do differently today to make a difference for our patients tomorrow?

People who raise concerns are asked to provide a solution and, with the support of the whole hospital community, action is taken as quickly as possible.

The approach from the trust is to focus on how a solution can be reached and not on what might prevent change occurring.

The CEO tweets daily about what was discussed.

Case study: Learning meetings

A GP Practice has a 15 minute meeting at the start of each day attended by all staff. Its purpose is to provide an opportunity for staff to raise concerns and share learning.

5.8.6 Despite the apparent benefits to staff and patients alike, we have been told that opportunities for reflective practice, especially M&M meetings are under pressure from management looking for cost savings, and that they are either being cut, reduced in frequency, or that staff are being expected to attend them in their free time. This is short sighted.

Conclusion

5.8.7 Opportunities for reflective practice play an invaluable role in patient safety and staff well-being and need to be encouraged and resourced. It needs to be recognised that investment in these areas will result in staff who feel valued and supported to contribute their best, thereby making the service they provide safer, more effective and productive.

5.8.8 In addition, wherever possible staff should be authorised to implement remedies themselves, and to report their conclusions and actions to relevant levels of management. Employers and staff should seek ways to share these ideas, both within their organisation and with others. New initiatives should be supported and encouraged by senior leaders by providing time and facilities for these to take place.

Principle 6: Culture of reflective practice

There should be opportunities for all staff to engage in regular reflection of concerns in their work.

Action 6.1 All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.

6

Improved handling of cases

6.1 Introduction

6.1.1 One of the most striking features of the meetings we had with individuals and organisations was the number of long running, unresolved cases that might have had a successful outcome if they had been handled well from the outset. This would have avoided a great deal of pain and expense. One CEO told us that with hindsight an open and honest conversation around a table might have saved years of legal proceedings, investigations, and anguish for many people, as well as huge cost.

6.1.2 Delays can have a massive impact on individuals, particularly if they are suspended or on special or sick leave. Suspensions increase their sense of isolation and can contribute to, or exacerbate, stress and in some cases mental health issues. Extended periods of leave can also lead to financial difficulties, adding to the stress. In some cases it was impossible or impracticable to get the full picture because of the lapse of time and the ensuing complexity. Fortunately, as I was not seeking to reopen past judgements I did not need to. However, this was indicative of the complexity of some cases, and evidence that the facts can get lost over time. In some cases I received a number of irreconcilable versions of events. I suspect that in some of these it would be impossible to resolve the differences, whatever time and resource were devoted to the task.

6.1.3 Once cases and positions become entrenched, it is clear that it is much harder to resolve them. There is also a risk that people lose sight of the original concern, and become more focused on the rights and wrongs of the aftermath and processes, such as, for example, whether an investigation has been done by the right people who were independent and had no conflict of interest. As it becomes harder to establish the facts, and disputes harden, the parties involved may find it increasingly difficult to accept the outcome of any investigation. Mutual suspicions and antagonisms grow, motives are continually questioned and a sense of perspective can be lost.

6.1.4 Intervention by lawyers can formalise cases too early, and polarise positions. Risk-averse advice can get in the way of a common sense solution. It was suggested by some that lawyers should only be used as a last resort.

> *"Entering into a legal battle inevitably polarises parties, and removes the focus from the public interest issue. It can also be very costly to both sides."*

> *"On the whole cases were not in fact about legal issues, they were about the breakdown in human relationships and the inability to repair them."*

6.1.5 We also heard that cases become a Human Resources (HR) issue too quickly where an organisation will 'focus on the person not the ball'.

> *"It appeared that HR were more worried about the organisation's reputation…"*

6.1.6 We heard of one example where a concern was not well handled in the first instance, leading to a CQC investigation. However, the handling of the situation once it had been escalated was excellent and the issues were quickly resolved with a very good outcome.

Case study: Handling a case well after it has been escalated

Staff on a particular ward tried to raise a concern with their line management, and when it was not addressed locally, with more senior management. Somehow their concerns were not picked up, so they took them to the CQC. The CQC investigated and found that their concerns were valid.

The trust's response was exemplary. Senior management, including the CEO, engaged immediately with staff, involved them in finding solutions, supported everyone and ensured no one was blamed or made a scapegoat. They also brought in a team coach to rebuild trust.

Staff morale and retention has gone up, sickness absence and resignations have gone down.

Conclusion

6.1.7 The lesson I drew from the evidence was that it is vital that cases are handled well and quickly. The more issues can be 'nipped in the bud' by establishing facts early on, with a degree of independence if necessary, and by communicating better at all stages, using mediation if needed, the greater the likelihood that there will be a successful outcome.

6.1.8 The rest of this chapter sets out what I consider to be necessary in terms of handling concerns:

- informal and formal concerns, including involvement of the executive team and logging and keeping track – see 6.2
- anonymous concerns – see 6.3
- investigation of concerns including timescale, independence and feedback – see 6.4
- overuse of suspension – see 6.5
- mediation and dispute resolution – see 6.6.

Some trusts will already do some or all of what is described. However it was clear from our evidence that many do not.

6.2 Informal and formal concerns

6.2.1 As discussed in 5.3, it is important that staff know how and where to raise concerns.
In addition, it needs to be clear what should be done with concerns that have been raised i.e. how these are investigated and how to communicate with the person who raised them. However, our research suggested that a sizeable minority of staff are unclear about the process (see 3.2).

6.2.2 Our research also showed that people raise concerns in a variety of ways, and frequently do not need to refer to or use whistleblowing policies. Rather, people resort to the whistleblowing procedure because they have repeatedly entered their concern through the incident reporting system or tried to raise it informally to no avail.

Where concerns are first raised – formal and informal

6.2.3 Good policies are flexible with regard to the permitted modes of raising concerns (verbal, written, electronic) and are clear about external options such as reporting matters to the CQC, Monitor and the NHS TDA. They should not deter staff who feel the need to go to a regulator (see paragraph 5.3.26). They should also be clear that they apply to the raising of all staff concerns whether or not staff consider that they are whistleblowing.

6.2.4 Of the 21 trust whistleblowing policies analysed, most advised raising concerns verbally with the line manager in the first instance, but in writing beyond that. This was consistent with the practice indicated through our staff surveys. Over half the staff responding to our surveys reported that they first raised their concern with their line manager. The majority did so informally. A minority reported doing this in writing.

6.2.5 The interview-based research also indicated that raising a concern usually starts informally. There were differences of opinion about how easy it is to raise concerns informally with staff at a senior level. Manager interviewees appeared to be supportive of this informal approach but some other interviewees noted that raising concerns informally at a higher level only worked for people who are confident enough to do this.

6.2.6 In an organisation that has embedded a safe and learning culture of the kind discussed in chapter 5, it should be possible for staff to raise minor concerns informally within their teams or elsewhere in the organisation if necessary and get these issues resolved quickly.

6.2.7 However, there will be times when the concern is more serious, or when there is genuine disagreement about the seriousness of the concern or how to handle it, and the person raising it considers an informal approach is not appropriate or has not been successful in resolving the issue. In such cases there should clearly be a mechanism for formally logging the concern and reviewing how it is being handled. We learned of examples of trusts that already have effective processes for reviewing the handling of formally raised concerns.

Case study: Regular review of staff concerns

A trust reviews all staff concerns on a weekly basis led by the medical director, and chief nursing officer.

At this meeting a decision is made as to the appropriate level of action and investigation. This may involve an internal or external investigation to establish the facts, seeking further information to establish how serious it is, or taking an issue up with an individual. Progress on existing cases is reviewed and all are monitored until the case is closed.

Overview and review by the executive team

6.2.8 Oversight and review by a senior member of the executive team, preferably the executive board member with responsibility for safety and quality (see paragraph 5.3.12) is a key element of an effective system of handling formal concerns. A common feature of a number of the high profile cases of substandard and unsafe care and treatment was the lack of awareness by the leadership of the existence or scale of the problems within their organisation. We heard about the risk that middle managers may seek to 'contain' problems, trying to deal with them themselves without notifying directors. Regular review by the CEO or his/her nominated board director will ensure that the senior leadership has full sight of issues within their organisation.

Logging and keeping track of concerns

6.2.9 Once a concern is raised formally, it is essential that organisations provide a straightforward system for logging them. This will provide a clear trail of who did what and when but can also:

- reduce the risk of subsequent confusion or disagreements, for example in relation to performance management action (see 5.4) or referral to a professional regulator (see 7.7)
- facilitate monitoring of trends and themes for organisational learning.

6.2.10 There was strong support for a more systematic method of recording or logging concerns in the same way that organisations have a duty to record and investigate health and safety incidents. We heard that local risk management systems (LRMS) could be adapted to meet local needs. Any system must be simple and user friendly both for staff inputting information and for the organisation as a whole for identifying trends and themes.

6.2.11 Once a concern has been logged, there needs to be a clear statement for the member of staff raising a concern about how the concern will be handled and what they can expect from the process. This could be in writing and an automated response should be possible if the concern is logged electronically.

6.2.12 There needs to be a clear process to ensure the concern is tracked and regularly reviewed; that it is dealt with quickly; and that there is no risk that it falls into a 'black hole'. Investigations and feedback are discussed in more detail in 6.4, but it is essential that the person who raised the concern is kept informed of progress and any delays are explained.

Knowing what to do with the concern

6.2.13 The person receiving and logging the formal concern needs to know what to do with it once they have recorded it. They will clearly need to decide to whom they should pass it if they cannot deal with it themselves. The skill to do this will be developed in part through training, which is discussed in 7.1. The system also needs to support the process and the recording mechanism needs to facilitate onward referral where required. Recording each step of the process in this way will ensure that the concern cannot become 'lost in the system'.

Conclusion

6.2.14 Wherever possible concerns should be raised and handled informally. It is nonetheless good practice to record them – and what is done about them – in case there is any need to refer back to them later. This could be achieved, for example, through the minutes of a team meeting, or retention of relevant emails.

6.2.15 There needs to be a clear process to report concerns more formally when informal handling is inappropriate. A well run process will provide a clear trail of who did what and when, reducing the risk of subsequent confusion or disagreements. Proper recording of formal concerns also aligns with the values of openness and honesty, by demonstrating a transparent approach to how they are handled.

6.2.16 Systems and processes for recording and monitoring concerns should take into account the following good practice.

Good practice – Handling concerns (recording and monitoring)

- The records of formally raised concerns include:
  - the date on which the concern was made, and when it was acknowledged
  - a summary of the issue and any supporting evidence provided
  - any patient safety issues raised by the concern
  - the gravity and urgency of the issue in the view of both the person raising the concern and the person recording it
  - any actions the person raising the concern(s) considers should be taken to address the issue and by whom
  - the wishes of the person raising the concern regarding disclosure of their identity to others, and confirmation that it has been explained to them that it will not always be possible to protect their identity
  - who will be responsible for taking action on the report.
- Once logged a copy of the record is given:
  - to the person raising the concern
  - the CEO or a designated board member, anonymised if requested, unless that would prejudice the CEO/board member's ability to act on the report. This copy includes what action is to be taken.
- There is a process for onward referral, both internally and externally, and monitoring to avoid cases being 'lost in the system'.
- Feedback is provided, whatever the outcome and whether or not a formal investigation takes place, to all those involved with raising, managing or monitoring the concern, including feedback on progress and the reasons for any change to the agreed timetable.
- The CEO or designated board member regularly reviews all concerns that are brought to their attention; and where they consider it appropriate, the regulator relevant to the case (either system or professional) is informed.
- Anonymous concerns are classed as formal concerns, recorded and followed up in the same way as other formal concerns (see 6.3).
- Appropriate training is mandatory for everyone in an organisation who may receive concerns from staff. It includes the organisation's procedures for recording and handling concerns (see also good practice in 7.1).

Principle 7: Raising and reporting concerns

All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Action 7.1 Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.

Action 7.2 All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.

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6.3 Anonymous concerns

6.3.1 We heard the terms confidentiality and anonymity used interchangeably. It is important to note that the two are not the same. If a concern is investigated respecting the confidentiality of the person speaking up, their identity is known by one or more people but not widely. It can be difficult to maintain confidentiality if concerns are to be investigated. If a person raises a concern anonymously their identity is not known by the recipient. However, in small departments and organisations it might be possible to deduce who raised an anonymous concern.

6.3.2 We heard differing views about whether it is desirable to allow concerns to be raised anonymously or not. It can be harder to follow up a concern that is raised anonymously as the information may be vague and there may be occasions where there are question marks over the motive. Some sectors outside of health have confirmed that they discourage anonymous reporting although do permit it. Some other countries have introduced restrictions on anonymous reporting.

6.3.3 The majority of regulators in England that engaged with the Review confirmed that they do allow anonymous reporting although some highlighted the limitations this could place on them in terms of investigation.

6.3.4 For those who want to raise a concern, having the option to do so anonymously would clearly be a safe way to do so, free from real or perceived ramifications. This was borne out by our staff surveys where the majority of staff working in both NHS trusts and in primary care agreed that having the ability to report anonymously would make it more likely that staff would raise a concern (see 3.2).

6.3.5 The general consensus amongst the parties we spoke to was that anonymous concerns should be allowed. The overarching message was that it was better to have concerns raised in any form than not at all. However, it was suggested that a high volume of anonymous reporting could be an indicator for a lack of trust in the organisation. Some non-health sector organisations monitor the ratio of anonymous to identifiable concerns with the aim of reducing the proportion of anonymous concerns.

6.3.6 In an ideal world, it would clearly not be necessary for staff to raise concerns anonymously. Raising concerns would be an everyday part of work as described in 5.3. We are some way off of this. Mechanisms to enable anonymous raising of concerns will be needed for the foreseeable future.

6.3.7 However, having received a number of anonymous concerns during the course of the Review, some copied to multiple organisations, I was concerned that there was a danger that concerns raised in this manner:

- might not be taken as seriously by recipients
- might fall between two stools with each organisation thinking the other would take action
- might be discarded without logging
- might, when there are other pressures, be least likely to be followed up.

6.3.8 I used one anonymous letter copied to me as well as four other recipients as a case study to investigate this further. It demonstrated that receiving anonymous concerns about complex cases with an interest for multiple organisations, whilst perhaps not the most favoured option, could be taken seriously and acted on effectively to keep patients and staff safe.

Case study: Anonymous concerns sent to multiple recipients

The Freedom to Speak Up Review received an anonymous letter raising concerns about a clinician at a trust. This letter had also been copied to the CEO of the trust, the relevant system and professional regulators and a union. After about 6 weeks, the Review team contacted these organisations to identify what action, if any, they had taken in response to this letter. All organisations confirmed that they had received the letter. The action they had taken is summarised below:

The trust

- CEO appointed two executive directors to undertake an initial review of validity of claims
- trust alerted the relevant system and professional regulators to the letter and the initial plan of action
- staff interviews held
- decision taken to investigate
- clinician involved informed of content of letter and anticipated timeframes of investigation
- data gathering and interviews started.

System regulator

- Inspector liaised with trust
- case flagged on the weekly CEO briefing
- regular updates of action by the trust and preliminary findings received
- case to inform planning of routine inspection of the trust.

Professional regulator

- Regional officer asked to liaise with the Responsible Officer for the trust about allegations in the letter
- system regulator contacted to establish their plans and share relevant information.

Union

- No action taken as letter sent to CEO of the trust and relevant system and professional regulator
- information kept on file.

Conclusion

6.3.9 I have been persuaded that anonymous concerns have an important role to play in ensuring patient safety even though there are limitations in how they can be followed up. They should be recorded as a formal concern – see Principle 7 in 6.2.

6.4 Investigation of concerns

Introduction

6.4.1 We heard from a number of contributors that what was needed first and foremost was to establish the facts and to examine the evidence. Yet too often this was not done soon enough or at all.

Establishing the facts

6.4.2 Establishing the facts is key to the effective handling of any concern that is raised. This should include examining possible system causes for the concern as well as potential solutions and remedies. It should not be about establishing blame or culpability. If, once the facts have been established, it is suspected that there are failings by individuals that genuinely warrant disciplinary action, this should be pursued separately in line with the concept of a 'just culture' described in 5.2.

6.4.3 We heard from many contributors how, when cases become embroiled in HR and employment issues, the initial concern that was raised can be lost. This is particularly troubling if patient safety is at risk. The focus should be on the concern that has been raised, how serious an issue it is, how to resolve it and how to share the learning. Instead, I was informed that the focus tended to be on who is at fault and who should be disciplined. Too often the process seems to result in the person raising the concern being the subject of disciplinary or other adverse measures.

6.4.4 Our staff surveys indicated that only around half of concerns are investigated and in about a quarter of cases staff do not know if their concern was investigated at all (see 3.2 and Annex Di). The importance of feedback is discussed in more detail later in this section.

6.4.5 When a concern is raised, irrespective of motive, the priority must be to establish the facts fairly, efficiently and authoritatively. In particular it is essential to identify if there is a patient safety issue and, if so, to address it. How this is done will depend on how serious the issue is. For something fairly minor that is raised informally, this might be something that can be done jointly within the team, for example at a Mortality and Morbidity or other meeting.

6.4.6 It may not always be possible to resolve issues so easily or informally. There may be differences of recollection or opinion, tricky interpersonal relationships, or the issue may be sufficiently serious that it is important to have an independent assessment of the facts, for example, from someone outside of the department or even the organisation.

> "*Whistleblowing isn't about keeping everybody happy – it's about getting to the facts, isn't it.*"

Positive experiences

6.4.7 A well-handled investigation can be key to resolving an issue quickly and amicably.

Case study: The benefits of handling concerns well

A senior clinician had serious concerns about a planned merger of departments and raised them with the CEO. The consultant was then contacted by her HR Director, who assured her that her concern would be looked into and that it was being recorded and treated as a protected disclosure. An independent investigation was set up, in consultation with the consultant to ensure she was satisfied with the choice of investigator, and she was kept in the picture at all times. The investigation did not uphold the concern, but the clinician accepted the finding and the rigour of the process.

She later overheard colleagues discussing that raising concerns was a waste of time. She disagreed, and told how she had spoken up, her concerns had been thoroughly investigated, and she had felt well supported and protected throughout. She said she would encourage them to do the same.

6.4.8 The written contributions and meetings identified examples of practices that had led to positive experiences for those who had raised concerns. These included:

- collaboration between medical and nursing directors
- close working relationships between clinicians and managerial staff
- advice from external experts
- protection of identity.

6.4.9 Focusing on issues when they are 'small' and/or isolated can prevent them escalating or happening elsewhere in the organisation.

Poor practice

6.4.10 However, the written contributions and meetings also identified many examples of poor practices in terms of the investigation process. These included:

- concerns not acknowledged
- failure to investigate and act
- 'biased' investigations
- lack of transparency and openness
- poor communication.

6.4.11 There were also concerns about unsubstantiated and false allegations.

Timescale of investigation

6.4.12 The quicker an issue can be investigated the better. There was overarching support at the seminars for logging receipt of a concern and a timescale for acknowledging its receipt. However, there was little support for a nationally specified timescale for completing investigations. It was accepted that different issues would need different approaches and the key was to inform the person who had raised the concern about the expected timescale for investigation and of any changes to that.

Investigation

6.4.13 Seminar participants agreed that is was key to have:

- arrangements for fair and proportionate investigations only independent of the organisation where appropriate
- a pool of people who are trained to undertake the investigation of concerns.

6.4.14 This was reinforced at meetings with representatives from other sectors who confirmed that:

- trained investigators can make a real difference
- investigations should be undertaken separately from the local team
- it is important that investigations are seen to be done properly and that appropriate resourcing is provided.

6.4.15 Of course there will be occasions where a concern cannot be dealt with quickly and simply. This reinforces a point frequently expressed to the Review that a one size fits all model for handling concerns is not possible.

> *"There are also the cases which become more complex than initially envisaged, with ongoing investigations that can be unsettling to everyone involved."*

6.4.16 However we did hear a range of ideas for what a good investigation process would look like, which, taken together form the principle ingredients of good practice. These are incorporated into the good practice summary at the end of this section.

Independence of investigation (including external investigation)

6.4.17 The need for, and value of, independent investigation of concerns was highlighted by many contributors. A solicitor with experience in handling whistleblowing cases across different sectors noted that one reason whistleblowing goes wrong in the

NHS is a lack of independent investigation. Other contributors also expressed scepticism and distrust of investigation of their concerns.

> *"Where [the issue is one of] processes rather than individual competence, […] the familiar problem of those in charge of the systems investigating themselves arises."*

> *"Reviews were often said to be dealing with […] concerns, but lacked integrity and did not intend to resolve the issues so much as push them under the carpet. It made little difference whether they were carried out externally or internally; in both scenarios, it was possible to engineer findings to evidence a premeditated outcome."*

6.4.18 The value of having an independent element to the investigation is that it provides objectivity so that the conclusions are more likely to be accepted by all sides, and bring closure to the issue. There were differing views as to whether investigation of concerns should be independent of the team only or independent of the organisation. Although some thought an investigation should always be external to the organisation, the majority advised that concerns should be investigated by people who are independent of the issue being looked into and that potential conflicts of interest should be identified and avoided. This did not mean necessarily that concerns had to be investigated by people external to the organisation. Staff from other departments or sites might be an option. It was noted that this might be more challenging in highly specialised areas or small organisations, although reciprocal arrangements with neighbouring services might be possible.

6.4.19 I do not consider it would be fair to insist that someone raising a concern should have an automatic right to request an external independent investigation. Nevertheless there will be many circumstances where external independence would be desirable. The degree of independence needs to be proportionate to the gravity or complexity of the issues and the seniority of those involved where it will be harder to find someone within the organisation who does not know them.

> *"An external team can provide a catalyst for dialogue where communications have broken down, often pointing out areas for change on both 'sides' and providing a calm and credible explanation for behaviours and attitudes which may be a result of pressures in their own jobs."*

6.4.20 Wherever investigators come from two things are essential. The first is that they have appropriate training and know how to conduct, and report on, an investigation quickly and with impartiality. The second is that they have dedicated time to do it, and are not being asked to 'squeeze' it into their other duties. It may indeed be helpful to establish a panel of accredited investigators or experts to whom an organisation could turn, similar to air accident investigators. This might be something that could be led by an Independent National Officer (see 7.6) or the National Reporting and Learning System (NRLS). It would have the additional benefit that this panel could be used as a means to identify system wide issues and share learning.

Feedback

6.4.21 One of the strongest messages from both individuals and organisations was that feedback after raising a concern is vital for both individuals and other staff in organisations. This should include evidence of action being taken as a result of a concern or reasons if not. Without feedback staff are unlikely to see the point of raising concerns in the future, there may be suspicion about action or inaction, and there will be lost opportunities for wider learning.

> *"If a member of staff is bothered enough to identify a serious problem and identify a sensible solution then there should be an ethical obligation for somebody appropriate to sit down with them and talk it through, even if it is unfeasible for reasons they hadn't understood."*

6.4.22 The results of our staff surveys indicate that there is still more to do on this:

- 26.6% of trust staff who answered this question (493 of 1855) noted that they were not told the outcome of the investigation into their concern
- 20.6% of primary care staff (77 of 374) noted that they had not been told the outcome of the investigation into their concern.

6.4.23 The qualitative information we received confirmed that the absence of feedback:

- could deter people from raising concerns in the future
- could trigger unnecessary escalation of the concern either internally or externally
- made it more likely that the person raising the concern would feel frustrated or aggrieved.

6.4.24 Many contributors were aggrieved at the way their concerns were treated. Some of these people would have been more likely to accept a decision, even if they did not agree with it, if they had been involved in the process and given feedback from the outset.

> *"The thing that makes me most angry was that no-one had a duty to explain why the decision was taken that this service improvement, which appeared to be feasible, affordable and life-saving, was not going to happen. I think if that had happened I would probably have found it easier to accept in the long run."*

6.4.25 Employing organisations did highlight the potential difficulty in providing full feedback while preserving the confidentiality of those involved. However, the interview-based research indicated that the importance of feedback is still not being thought about enough.

> *"They get an acknowledgement, and they know it's being taken forward. What I think we don't do so well, and what comes back to us, is we don't give detailed feedback as well as we might, and I think that's a gap for us if I'm honest."*

6.4.26 It may not always be possible to give full details of the conclusion. For example, the cause for a safety concern might be found to be inconsistent performance by a doctor who is not well. Even though it would not be appropriate to give full details to the person who raised the concern, there will always be some information that can be shared. In some cases it may be that the staff member would consent to disclosure of at least some personal information, or be prepared to discuss the problem with the person who raised the concern. Appropriate feedback can be adjusted to take account of the circumstances.

6.4.27 There should be a presumption that the findings of an investigation will be shared with the person who raised the concern and any other staff involved. If it is not possible to share the full report for reasons of confidentiality, as much information as possible should be shared, redacting or editing only what is essential to respect the privacy of other individuals involved. Confidentiality should not be used as a reason to give no feedback at all.

6.4.28 This will be an important step in maintaining the trust and confidence of all involved in the process that has been adopted. Even where direct sharing of information is inappropriate or impractical, for example where the information has come from an anonymous source, there are still ways to feedback to staff about concerns. Examples of what is happening already include:

- fact or fiction noticeboards to deal with concerns and rumours
- feedback on whiteboards, noticeboards and bulletins, for example 'you said, we did'
- weekly e-communications listing every concern raised by staff that week and the organisation's response and/or proposed action
- feedback from consultant and a clinical governance trainee review of specialty specific incident forms to the rest of the department.

Conclusion

6.4.29 Three main things came out of the evidence in relation to the investigation of concerns:

- the importance of establishing the facts
- the importance of doing so quickly and if

necessary, independently of everyone involved with the issue, in a way that has the confidence of all parties
- feeding back to the individual and sharing learning more widely.

6.4.30 A decision should be taken at a level of seniority appropriate to the gravity of the issues raised about the appropriate response, including, where relevant, a programme of proposed action to address the safety issue identified and any learning from it that might be shared more widely. This should also be shared with the person who raised the concern. Wider learning should be shared across the organisation (see 7.4 on transparency).

6.4.31 Investigations should be carried out in accordance with the following good practice which should be incorporated into the organisation's policy and procedures described in Principle 2.

Good practice – Handling concerns (the investigation process)

- The investigation of a staff concern:
  - is done quickly within an agreed timescale that is set out at the start. The person who raised the concern is informed of any changes to the timescale
  - is separate from any disciplinary process involving anyone associated with the concern where possible
  - has a degree of independence proportionate to the gravity or complexity of the issue
  - is conducted by appropriately qualified and trained investigators who are given the time to conduct and write up their investigation as per the agreed timescale. They are not expected to fit this into their normal work schedule. In cases involving death, serious injury or serious levels of dysfunction of system or relations, the investigators are not employed by the responsible organisation
  - seeks to establish the facts by obtaining accounts from all involved and examining relevant records
  - takes into account known good practice or guidelines including clinical guidelines
  - results in feedback of the findings and any recommendations or proposed actions to the person who raised the concern and all those involved taking into account confidentiality issues where necessary
  - confidentiality is not used as an excuse to refrain from providing feedback
  - ensures there is someone who keeps in touch with the person who raised the concern at all times to keep them abreast of progress, and to monitor their well-being.
- The outcome of the investigation is considered at a level of seniority appropriate to the gravity of the issues raised alongside, where relevant, a programme of proposed action.
- The trust has access to a panel of trained investigators, who can respond quickly and with the necessary level of expertise.
- Learning from the investigation is shared across the organisation and beyond where appropriate (see 7.4 on transparency).

Principle 8: Investigations

When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

Action 8.1 All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.

6.5 Overuse of suspensions

6.5.1 We encountered a number of individual contributors who told us they had been suspended after raising a concern and described the detriment this had caused to their professional standing and career progression.

> *"I pointed out gross injustices that were being perpetrated by the system and I was immediately suspended for alleged misconduct."*

> *"…after raising concerns I was excluded from work by my trust […] I was brought back after the trust reluctantly admitted that I had done nothing wrong."*

6.5.2 Figures from the National Clinical Assessment Service (NCAS)[79] show that during the year to 31 March 2014 in the NHS in England, 155 doctors and dentists were suspended using the Maintaining High Professional Standards (MHPS) Framework. On average, doctors suspended in 2013-14 spent 23 weeks excluded from work, an increase of three weeks on the previous year, with an estimated 4,100 weeks lost in total across the health service.

6.5.3 Of those doctors who returned to work in 2013-14, 15 had spent a year or more on suspension. Of the 150 cases resolved in 2013-14, 39 (26%) resulted in a return to work without any restrictions being placed on their practice; 37 (25%) doctors returned to work with restrictions on their practice; 15 (10%) were dismissed or removed from the list and 14 (9%) resigned. In the other cases a range of outcomes were reported or were not known.

6.5.4 Whilst it is not possible to know the volume of suspensions that are, or are perceived to be, related to the raising of concerns, we heard from HR, management and staff that suspension was overused. The general view was that suspensions should be the last, not the first, option considered.

> *"It is also fair to say that managers and senior management in some organisations often have a 'knee jerk reaction' and are too quick to suspend and discipline staff, perhaps when it is not necessary and to protect themselves and the organisation. Suspension should be a last resort, rather than a first response."*

6.5.5 Possible overuse of suspension was also raised in the interview-based research. A solicitor who worked for a number of sectors noted that use of suspension was a particular issue in the NHS.

> *"There is another thing that the NHS does to whistleblowers which I've not seen anywhere else […]. They will suspend you, but indefinitely, and you'll stay off for months and in some cases years while an investigation is supposedly going on which never really concludes."*

6.5.6 Whilst there are no doubt occasions where suspension will be appropriate to protect patient and staff safety, I heard how suspension could be deployed too quickly or used to 'penalise' a whistleblower.

6.5.7 Suspensions have an impact on the NHS in terms of the waste of skills and expertise and the cost of paying for agency staff or locums to cover suspended posts. However, the biggest impact is the personal cost for the individual suspended. This also applies to people who raise concerns who are sent on sick leave or special leave if their position within their team is considered untenable. Contributors described isolation, becoming deskilled, loss of confidence and psychological damage. The perception among other staff is often that the suspended member of staff has done something wrong and clinicians who have been suspended can find it hard to return to work. This is in contrast to the aviation industry where we were advised that in some fields it is seen as routine for staff to be at home for a period while investigations take place.

79 *National Clinical Assessment Service: Use of exclusion and suspension from work in England*, NHS Litigation Authority, 5 June 2014

"The […] process is so slow and long drawn out while the doctor remains excluded/suspended from work, that the doctor is at risk of losing clinical skills."

6.5.8 Suspension and special leave seem to me to be avoidable in many circumstances. Alternatives might be, for example, voluntary restriction of practice, or an alternative position in another part of the organisation as a development opportunity, particularly in cases where relationships were the issue rather than clinical expertise. I agree with the suggestions of some contributors that in cases where suspensions could not be avoided:

- they should be signed off by a senior person within the trust
- investigations should be rapid so that time on suspension is kept to a minimum
- there should be regular monitoring to review the ongoing justification for the suspension.

6.5.9 There was also a suggestion that employers should be transparent about the number of suspensions due to raising concerns and that regulators might use this information as one indicator of how concerns are handled. I believe this would provide considerable encouragement to employers to think through and apply a consistent approach to staff on suspension.

6.5.10 Some trusts are already taking action to reduce the use of suspensions.

Case study: Action to reduce suspensions in a trust

A new HR Director discovered the trust had 17 people on suspension. One had been suspended on full pay for over 2 years. She revised the trust policy so that:

- all suspensions must be signed off by the HR Director, or deputy if she is unavailable
- the only grounds for suspension are:
  likely to do harm to a patient
  likely to do harm to a colleague
  likely to tamper with evidence.
- even where these grounds are met, the first step is to try to redeploy the person to a role on another site, or to a non-patient facing administration role, so that they can be supported and are not left isolated at home.

There are now only one or two people suspended at any one time, and another one or two redeployed within the organisation.

Conclusion

6.5.11 I am persuaded that suspension is overused on staff who raise concerns. There is some good practice that would ensure that this action is taken only when really needed to protect patients and staff.

Good practice – Suspensions and special leave

- Suspension of staff involved when concerns are raised is a last resort, where there is no alternative option to protect patient or staff safety, or to maintain the integrity of any investigation or for another compelling reason.
- Alternatives to suspension or special leave are always considered including restricted practice, mediation and support and temporary redeployment to a non-patient facing role or to another site.
- A decision to suspend or give special leave to someone who has raised a concern is only taken by a nominated executive director or directors with the authority of the CEO.
- Any decision to suspend or give special leave is accompanied by an explicit and recorded consideration of all reasonable, practicable alternatives that have been considered and the reasons they were not appropriate.
- The number of suspensions or special leave resulting from raising concerns and their ongoing justification is regularly reviewed by the board.
- The number of suspensions and special leave resulting from raising concerns is shared with regulators and used as an indicator by both the board and the regulators to consider how concerns are handled in the organisation.
- Staff who are suspended or on special leave following raising a concern are given full support in line with Principle 11 in 7.2.

6.6 Mediation and dispute resolution

Introduction

6.6.1 The NHS is a pressured and organisationally complex workplace. It would be unrealistic to expect the service to run without some professional disagreements or conflict. However, poor working relationships can lead to poor communication and impact adversely on team dynamics. This can lead to important issues relating to individuals or systems being ignored or not tackled. Ultimately it can be a risk to patient safety. Action therefore needs to be taken to address relationship issues before they escalate and put patients' lives at risk.

6.6.2 We heard a number of examples of difficult situations that had arisen out of poor relationships between individuals or within teams. There can be many reasons for both professional and personal conflicts and these can be exacerbated when concerns are raised about an individual, their clinical practice or their team, particularly if they are not well handled. For example, if a concern is perceived to be a threat to professional pride or integrity there is a risk that the focus becomes personal, leading to counter allegations, instead of being depersonalised and focusing on facts and evidence.

6.6.3 We heard of cases where the raising of concerns had turned previously good working relationships sour, and caused people to behave in ways they would probably never have done otherwise. Some of this might be the result of stress. As in all walks of life, there will be times when stress affects how people behave. Confusion, anger and frustration may all be symptoms of this stress and may impact on professional and personal relationships.

6.6.4 We also heard about cases where relationships between people had broken down to a point where they were unable to work together. In the NHS, where some skills are highly specialised, we cannot afford to let this happen.

6.6.5 There appeared to be widespread support for developing a culture of 'sitting round a table and talking' openly and honestly at the outset instead of resorting to formal, sometimes legal, process. This would be particularly helpful in:

- addressing relationship and personality issues
- discussing an individual's concern and how it might be resolved, particularly if there could be more than one view about whether the concern was valid and/or how to address the concern.

6.6.6 There was a clear view that many situations might be resolved faster, to the satisfaction of all parties, if people had simply discussed problems and concerns with each other at the beginning.

> *"...the facilitated workplace discussion did bring about actions that acknowledged culpability and made change based on this."*

6.6.7 Helping someone to develop self-awareness and moderate their behaviour is arguably more effective than disciplinary action in the first instance. However, repeated infringements of a type likely to undermine an open and honest culture should not be tolerated.

Mediation and dispute resolution

6.6.8 While there is no template for repairing relationships, bringing in a neutral third party such as a mediator can be beneficial. The mediator can help explore issues in a non-confrontational way, helping people to negotiate disagreements and jointly create a way forward. Mediation can explore constructive solutions to problems unavailable in legal and disciplinary processes to the mutual benefit of both the public interest and all those involved. Mediation could play a particularly valuable role where concerns relate to individuals who work closely together or when they relate to someone in the direct management chain.

6.6.9 Mediation was mentioned by a number of contributors as a means to help people and teams to resolve relationship issues or move on after a concern had been raised. In Canada, the Public Servants Disclosure Protection Tribunal encourages the use of, and facilitates, alternate dispute resolution (ADR) such as mediation and settlement conferences.

6.6.10 Some contributors also noted that mediation should be used early in the process, combined with a swift and impartial look at the facts, before relationships breakdown irretrievably. We heard about a number of cases where those involved considered that concerns could perhaps have been resolved if ADR and/or experienced mediators had been brought in sooner.

> *"Mediation needs to be an option at an early stage before parties become too entrenched for the process to be successful."*

6.6.11 Some written contributions described experience of inefficient internal mediation processes or lack of support for such processes.

Case study: Lack of local support for mediation

A junior nurse raised concerns, along with several colleagues, about safe staffing levels in the service they worked in. After having raised the concern informally with numerous managers in the service, they felt they were forced to pursue the matter formally; they considered this option to be a measure of last resort.

An external review was undertaken. It recommended that the junior nurses and managers in question engage in a process of mediation to explore and resolve the issues at hand. The managers refused to get involved and no further action was taken.

The junior nurse said that she was 'left to work in an environment where…there was little communication' and she 'fears for the safety of the patients being treated by the service.'

6.6.12 Trained expertise can be valuable to help rebuild and restore trust in a team after it has been through a difficult period as a result of an incident or a concern being raised. Where there are difficult problems to address, or behaviours that need to change, it can be helpful to have an open, facilitated discussion to create shared ownership of the problem and of the solutions. Although it can be demanding of resources and time, it can also bring considerable benefits in the longer term.

6.6.13 The role of mediation was strongly supported at the first three seminars but had a more mixed reaction at the final one. Overall, there was support for the NHS making more use of the process, skills and language of mediation. It was suggested by some that employers should consider developing these skills across the organisation, rather than investing the expertise in one person. These mediators could then support individuals and teams experiencing difficult relationships and help to repair broken relationships.

6.6.14 We also heard that the use of mediation can bring benefits over and above dealing with the issue at hand. Examples we were given included:

- helping to promote the well-being of the individuals involved
- helping to mitigate occurrence of mental illnesses such as depression and anxiety
- economic benefits, including savings on legal costs
- indirect costs such as reducing staff sickness absence and addressing recruitment and retention issues.

6.6.15 However, there were some contributors who were more sceptical of the value of mediation based on their personal experiences of it after raising a concern.

> *"A mediation meeting I had with the manager who recommended my sacking turned into a farce when instead of mediation [the manager] presented me with an alternative – accept an exit package or be sacked."*

6.6.16 We also heard concerns that:

- mediators might not be sufficiently attuned to the particulars of clinical settings and the complexities of medical opinions to be effective
- internal mediators may be inexperienced and of limited effectiveness
- internal mediators or a mediator funded by the organisation's management could not be considered neutral and would seek to 'push the management agenda' leading to the appearance of it being a box ticking exercise.

Conclusion

6.6.17 Mediation, reconciliation and ADR techniques should be employed where there are disputes between staff members or between staff and their employers, including those arising out of raising a concern, which impact on personal relationships and trust.

6.6.18 While some cases may not be fully resolved through mediation, I consider that mediation and other alternative dispute resolution techniques can play an important role in handling concerns. To be effective, organisations need to use properly trained and experienced mediators and, where appropriate, professional mediators who have the relevant experience in the health service. This should increase the likelihood of a good outcome in difficult or sensitive cases.

Good practice – Mediation, reconciliation and alternate dispute resolution (ADR)

- NHS organisations make full use of mediation, reconciliation and ADR expertise, whether internal or external, at an early stage with the agreement of all parties involved in a dispute or disagreement. It is particularly used:
  - where relationships are poor, to support remedial action to resolve issues before they break down irretrievably
  - where relations have broken down, to try to repair them
  - to build or rebuild trust in a team or a relationship where there has been a difficult issue
  - to support staff involved in a difficult case to prevent or support recovery from stress and mental illness.
- Mediation and similar techniques are undertaken with the agreement of those involved, respecting their confidentiality. Refusal to consent is never considered as a cause in itself for disciplinary action.
- Expert support of this type is also considered prior to, or instead of, disciplinary action where there are concerns about an individual's behaviours or their oppressive management style, in line with the concept of a just culture described in 5.2, although repeated infringements of a type likely to undermine an open and honest culture are not be tolerated.

Principle 9: Mediation and dispute resolution

Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

Action 9.1 All NHS organisations must have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to:

- address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern
- repair trust and build constructive relationships.

7

Measures to support good practice

7 Measures to support good practice

Chapters 5 and 6 looked at how NHS organisations can create the right culture in which people feel safe to raise concerns, and how concerns should be handled. This chapter looks at what is needed to make the system work well. It covers:

- **training** – see 7.1
- **internal and independent support for staff** – see 7.2
- **support to get back to work** – see 7.3
- **transparency** – see 7.4
- **accountability** – see 7.5
- **external review** – see 7.6
- **coordinated regulatory action** – see 7.7
- **recognition of organisations** – see 7.8

7.1 Training

Availability

7.1.1 Although there is some evidence of good practice being applied, there is no uniformity in the availability of training in raising and handling concerns. Attempts are being made to address this, but these appear to be piecemeal and dependent on local engagement rather than part of a national strategy.

Case study: Train the trainers

A union has developed a training programme for its representatives to run in partnership with employers. It has been piloted with 100 participants.

The course aims to give an understanding of key messages and lessons from reports by Francis[80], Keogh[81] and Berwick[82], how regulatory systems work, how concerns can and should be raised and the importance of documenting information etc.

The aim is to equip participants with the knowledge and confidence to run short workshops in their own organisations on how to raise concerns and why this is important.

Training Need

7.1.2 Consistency of practice is important. Some NHS workers, such as trainee doctors and agency staff, will move between establishments on a fairly regular basis. They need to know and be familiar with how to raise concerns wherever they are, and whenever they arise. Serious harm can follow when expectations fostered in one workplace with an open culture, are dashed in another which has not achieved this.

7.1.3 Training of staff in whistleblowing practice and in raising and handling concerns is essential. Good training helps to energise and educate staff and equips them with the knowledge and techniques both to raise and, equally important, to handle, concerns when they are told about them by colleagues or they are involved in the issues that are reported. Raising a concern is not always easy even in an open culture. It may involve a need to reflect on one's own practice. It may require a sensitive approach to a colleague in difficulty. Hard-pressed managers will respond more effectively to concerns raised with clarity, sensitivity, and understanding of the context in which the organisation works. Handling concerns is likely to require not only skills in analysing issues, organising appropriate investigations and managing interactions between individuals who disagree with each other, but also judgement and a sense of proportion and perspective. Therefore it was not surprising that one of the most common suggestions we heard was the need for more training and for it to be consistent.

Content of Training

7.1.4 There is no accepted standard for what constitutes effective training in terms of raising and handling concerns. The content of training needs to equip people to deal with the standard procedures but also, and perhaps most importantly, how to: raise concerns in challenging situations; respond appropriately to a concern raised about one's own work or behaviour or that of one's team; and support individuals who have raised a concern and colleagues involved.

80 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013
81 *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, Professor Sir Bruce Keogh KBE, 16 July 2013
82 *A Promise to Learn – A commitment to Act, Improving the Safety of Patients in England*, National Advisory Group on the Safety of Patients in England, August 2013

7.1.5 Training needs to help people understand how to focus on the issue not the person, and how not to take concerns personally. The written contributions suggested that individuals at all levels often interpret concerns as personal criticism. When that happens there is a natural tendency to have a defensive reaction which immediately personalises the issues raised. This can lead to a focus on the motive for raising the concern rather than identifying the facts of the case, polarisation of positions, and a breakdown of working relationships.

> *"Once employers respond defensively and ignore the validity of the concerns raised many staff rightly fear detriment."*

7.1.6 The role of Human Factors[83], the understanding of how human behaviour, workplace, equipment design and culture affect performance, is critical. Some trusts and medical schools already build human factors considerations into simulation training. I believe Human Factors science needs to be a standard part of training for everyone in healthcare. They need to understand how people react under stress, how to challenge hierarchies and tolerated practices, and the importance of not being afraid of stating the obvious.

Case study: Understanding human factors

An anaesthetist was intubating a patient who had inhaled vomit and was having difficulty breathing. A junior doctor noticed that the patient's chest had stopped moving but was wary of commenting as it was very basic and he was conscious that the anaesthetist was more senior and it was his area of expertise. However, he had recently been on Human Factors training and understood that when people are focused on one particular task they can miss wider issues. He spoke up. The anaesthetist had indeed been so focused on the complexity of the situation that he had not noticed. Sub optimal ventilation was confirmed. Suction was called for unblocking the tube and improving ventilation immediately. A potentially serious event was avoided.

Training for all staff

7.1.7 Raising concerns and being able to accept, with insight and without being defensive, concerns being raised about one's own practice is a fundamental skill that all NHS workers need to have. It should be part of pre-registration training for all students working towards a career in healthcare. Students and trainees are future leaders and need to be given the right skills early on if they are to become good leaders for the future. Health Education England (HEE), the Medical Schools Council and regulators responsible for training, for example the GMC and NMC, need to ensure that these skills are embedded in undergraduate and postgraduate curricula.

> *"…students bring a fresh perspective and are less likely to have been injured by the prevailing culture of fear and blame. They therefore represent a section of the workforce that could, with the right training and support, be crucial agents for bringing about the desired change in culture."*

83 A definition of Clinical Human Factors is "Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation or human behaviour and abilities, and application of that knowledge in clinical settings." See Clinical Human Factors Group website http://chfg.org/what-is-human-factors

7.1.8 However this is not just about students and trainees. All staff need some form of regular training on raising and handling concerns. A standard course would not be appropriate for everyone at every stage in their career. What might be sufficient for a trainee at the outset of their career may be different from what is required for a senior consultant or manager who is likely to be both raising and receiving concerns and needs to know how to do both. The training needs of staff who are unlikely to have hands-on care of patients may also be different.

7.1.9 What was clear from discussions was that all staff need to establish a common language and understanding about concerns, and receive training to foster mutual understanding and acceptance. A multi-disciplinary approach to training was suggested as a means by some to break down silos between staff groups.

Process of Training

7.1.10 Delegates at seminars emphasised that training needs to go beyond e-learning, and that this topic is much better handled through discussion and reflection using scenarios and role play. Some employers already use real incidents as a basis for discussion and training.

Case study: 'The Human Factor: Learning from Gina's Story'

A patient at a trust suffered serious avoidable harm as a result of a mistake made during a routine procedure. The trust wanted to learn from its mistakes and undertook a thorough investigation of what went wrong and why.

As a result of the investigation, a number of changes were made to the way the procedure is conducted, so that it is now safer. These changes were specific to the procedure in question, but there were also general lessons such as the importance of human factors and speaking up.

The trust made a video of the incident which they use as a basis for discussions and training throughout the organisation about speaking up and learning from incidents. They have made it available online[84].

Training for managers and others in handling concerns

7.1.11 As set out in 3.2, managers (particularly middle managers) have been subjected to much criticism from individual contributors with claims that they can act as a barrier to concerns being raised higher up within the organisation or that they can be involved in collusions and cover-ups. While this may be correct in some cases, the difficult position in which managers find themselves has to be understood. They will often be under great pressure, imposed by their leaders, to deliver challenging targets with limited resource. They may be required to manage underperforming staff. Approaches from staff raising concerns will only add to the pressure on them. They will often need considerable understanding, patience and resilience to satisfy these multiple demands. Added to those challenges, they also have to manage staff who may not agree with the outcome of an investigation or who seek to use the reporting of a concern as a means of resisting legitimate performance action.

84 http://youtu.be/IJfoLvLLoFo

7.1.12 In order to deal with these extremely difficult situations, managers need advanced training to deal with concerns which are addressed to them or affect them or their services.

7.1.13 We heard that some training for managers is already available. It needs to be uniformly available to all staff in managerial positions, and aligned to the training given to other workers.

Case study: Training for managers

The Whistleblowing Helpline offers training to managers and those responsible for development of policy and best practice in the NHS. The training gives guidance and advice on how to receive concerns and how to create a positive culture where people are able to speak up without fear of recrimination.

7.1.14 Managers also need to have training in other relevant skills such as communication skills and identifying and managing bullying. The latter is particularly important as bullying behaviour is a deterrent to speaking up.

> *"There is little doubt that training, communication and leadership are significant issues in moving forward. Ensuring that staff are exposed to good managers with great listening and communications skills will be essential for the NHS."*

7.1.15 HR staff and union representatives may also benefit from receiving additional training on handling concerns, in particular, explaining ways to resolve cases and to prevent them escalating.

Conclusion

7.1.16 Organisations should take into account the following good practice in terms of training on raising and handling concerns.

7.1.17 The importance of universal and consistent training is such that I believe there should be national standards, within a structure devised jointly by HEE and NHS England in consultation with stakeholders, such as NHS Employers, the Whistleblowing Helpline and other providers of training. This is important to ensure that there is consistency amongst those delivering the training about the content, the messages, the level of detail and the expectations and advice both on how to raise and how to receive and handle concerns.

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Good practice – Training staff in raising and handling concerns

- Every member of the organisation participates in training on raising and handling concerns. It is designed to meet their likely needs with some groups, such as directors, managers and HR, having a more detailed focus on handling than others.
- Training is done in groups, face to face and preferably multidisciplinary, making use of scenarios and role play.
- Training ensures all staff gain an understanding and expectation about the policy, process and support available and what is appropriate and acceptable behaviour when raising and handling concerns. It includes:
  - the process to follow when a concern is raised including the approach to take in terms of investigation and how to prevent a situation escalating
  - how to raise concerns with tact to avoid causing offence or provoking defensive behaviour, including raising concerns in challenging situations e.g:
    - where the person raising the concern has been involved personally and might share some of the responsibility
    - which might affect colleagues or be unwelcome news for a senior manager
    - where it is likely that others may disagree with the person raising the concern
    - where the person raising the concern does not have the full picture.
  - consideration of human factors, how people react under stress and how to challenge hierarchies
  - how to respond appropriately to a concern raised about one's own work or behaviour or that of one's team
  - how to support an individual(s) who raised a concern, and any colleagues involved.
- Training and guidance is available on managing performance issues including if and how they may relate to whistleblowing.

Principle 10: Training

Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

Action 10.1 Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.

7.2 Internal and independent support for staff

Introduction

7.2.1 Most people who had a positive experience of raising concerns said they felt supported throughout and were able to maintain good working relationships with their colleagues. Support can take many forms including:

- practical and moral support from experienced, knowledgeable, and reassuring colleagues
- raising a concern as part of a group or team rather than alone
- direct access to specific support such as HR advice
- counselling (for example, through occupational health)
- ability to access advice from 'experts' or 'support buddies'.

7.2.2 The negative experiences, by contrast, were often characterised by a total lack of support and 'feelings of powerlessness'. Examples of issues raised included:

- no one to turn to in the organisation
- no access to senior management
- no HR support
- lack of counselling.

> *"My experience is very negative. I did not feel supported…"*

7.2.3 Raising a concern can impact on others, who might also need support, such as:

- any person about whom a concern may have been raised
- the wider team who might be affected by divided loyalties, and fear and uncertainty, which could impact on both team morale and engagement
- the person dealing with the concern who might not know what to do.

> *"The emotional impact on all those directly involved cannot be underestimated."*

> *"…you put your support around the person that the allegations are against as opposed to the person putting the claim in. For me it's the same process, they should both get support wrapped around them to help them through the process by which you prove or otherwise that there's an issue or not."*

Support for whistleblowers and others affected by concerns raised

7.2.4 Whistleblowers need support at various times:

- when thinking about raising a concern
- when reporting something that they are concerned about
- after having raised a concern
- to get back to work (if needed).

7.2.5 This might take the form of:

- people to offer advice and support
- pastoral support including counselling
- support from organisations such as unions, professional bodies and regulators.

7.2.6 In addition, similar support may be needed for the person a concern is about and/or the team affected by the concern.

7.2.7 Needs will vary and therefore flexibility rather than prescription is required in the support that should be made available to each individual or team. One size will not fit all.

Sources of advice and support

7.2.8 There should be a range of sources of advice and support that people can turn to, to ensure that, one way or another, an organisation hears about a concern and can take appropriate action. No person who raises a concern should be left feeling that they are not being listened to or that the issue they have highlighted has been ignored. That does not mean that every concern will justify action but, as a minimum, the member of staff should be reassured that they have done the right thing in speaking up and told why their concern has not resulted in any changes. The message must be that it is always better to err on the side of caution and speak up.

7.2.9 Our surveys showed that (see 3.2):
- when staff seek advice they are most likely to do so from a work colleague
- when staff raise a concern they are most likely to do so in the first instance with their line manager informally
- other people to whom staff raise concerns, if not their line manager (although in much lower numbers), include heads of department, HR, 'other internal' for trust staff and a designated person or a senior partner for primary care staff.

7.2.10 There needs to be a more formalised structure so that staff are clear who they can approach for support in raising a concern. The two most commonly raised ideas were:
- a local champion
- a designated board lead.

These ideas are not mutually exclusive.

Local champion

7.2.11 The local champion role described by contributors can take on a number of functions. This person can:
- ensure that any safety issue about which a concern has been raised is dealt with properly and promptly, and escalated through all management levels to the extent necessary
- intervene if there are any indications that the person who raised a concern is suffering any recriminations
- act as an 'honest broker' if someone is trying to delay performance action of any sort
- be involved in training staff to feel confident about speaking up, and how to receive and deal with concerns that are raised
- work with HR to address the culture in an organisation and tackle the obstacles to raising concerns
- share best practice examples and facilitate learning
- escalate concerns outside of their organisation, for example to the CQC, if they do not feel that appropriate or timely action is being taken by their employer.

Case study: An ambassador for cultural change

A trust has established a new role which they have called an 'Ambassador for Cultural Change'.

The post was established in response to the very low usage by staff of an external advice line for those considering raising concerns. The trust knew that it had to do something differently to encourage people to speak up.

The purpose of the role is to support and help drive a programme of change in the trust so that it becomes an open and supportive place to work. The Ambassador works independently and reports directly to the Chief Executive on a very broad range of matters that staff bring to her attention, such as safety, quality, welfare and process. Importantly, if she doesn't think that the trust is living up to its values, she is able to hold them to account.

She supports staff in raising concerns, offers reassurance to those reluctant to speak up, helps develop training and works across organisational boundaries to make the trust a safer place to be treated and a more open place to work. Since taking up the post, the number of incidents that have been reported and concerns that have been raised has increased dramatically.

7.2.12 A role of this nature in another trust has a wider remit that also includes patient complaints.

7.2.13 A role such as this can have a number of advantages. It:

- establishes at least one contact to whom staff could go for advice and support if they had a concern or thought their concern was being ignored
- demonstrates a commitment by an organisation to listen to their staff and treat them fairly
- offers a route to raise concerns that is outside of direct line management and HR structures, but with access to senior management, including both executive and non-executive board members, who can take appropriate action if needed
- is seen as independent, impartial and objective
- is someone who could 'tell it straight, have open and honest conversations and keep the temperature down' and act as a conduit between staff, senior managers and the board.

7.2.14 There was some discussion about both the title of this role and the job description. On the one hand there is a case for leaving it to each organisation to decide what works for them. However a stronger case can be made for some standardisation.

7.2.15 I am persuaded that there would be advantages to the creation of a local 'champion' role in every NHS organisation or group of organisations. Consistency over at least the name would mean that staff who moved between different establishments would always know where to go for support. I have considered a number of potential names for this role including Safety or Speaking Up Advisor/Champion/Guardian/Ambassador, Openness Advocate and Whistleblower/Raising Concerns Support Officer. What name is chosen matters less than a shared understanding of what it signifies. The role I envisage bears some, although not complete comparison to the well-established function of the Caldicott Guardians. Accordingly my tentative view is that an appropriate name would be Freedom to Speak Up Guardian.

7.2.16 A network of these postholders should be established for peer support, to share learning and identify trends across NHS organisations that might need to be shared with the National Reporting and Learning System (NRLS), CQC or others.

7.2.17 For this to work effectively the postholder needs to have the right interpersonal skills, courage, tenacity, and the respect of colleagues as well as the full confidence of the CEO. The postholder also needs to be pragmatic, fair and understand the structure of his/her organisation and its place in the healthcare system nationally.

7.2.18 Not everyone will want to approach a Freedom to Speak Up Guardian. It is important to have alternative routes available. For example, someone might prefer to speak to their head of profession or departmental lead. It is best that there are a range of people whom staff can approach all working to the same objectives, and who can work together to ensure consistency of approach across their organisation.

A designated board lead (executive and non-executive)

7.2.19 Some organisations may already have a **designated board lead**, who may be either an executive or a non-executive director (NED) with specific responsibility for whistleblowing. They may even have both. The general view was that this should be an oversight role, demonstrating the commitment of the board as a whole to effective handling of concerns raised by staff.

7.2.20 It would not be practicable for a **NED** to act as a sole point of contact for whistleblowers in an organisation, given the time constraints inherent in the role. However, it would be desirable to use a NED's ability to act as an independent voice and board level champion for those who raise concerns. The NED would work closely with the Freedom to Speak Up Guardian and, like them, could act as a conduit through which information is shared between staff and the board. The NED should be expected to provide challenge alongside the Freedom to Speak Up Guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why.

7.2.21 The **executive board lead**, or leads, would oversee internal processes and keep them under review, ensure staff felt empowered to raise concerns, ensure learning from concerns was shared across the organisation, and should be accountable for the treatment of whistleblowers within the organisation. They should have the executive responsibility to account to the board, for the system of handling concerns and supporting those who raise them. I suggested in 5.3 that this responsibility should sit with the person responsible for safety and quality, rather than HR.

7.2.22 An organisation might alternatively choose to nominate a range of directors, to enable staff to go to their professional lead or the leader with direct oversight of a particular area. The case study in 6.2.7 describes an organisation in which a panel of executive directors meets weekly to review all concerns to make decisions on the appropriate level of action and to report to the CEO. Such arrangements appear to be highly effective. Again the key is for the board and CEO to establish arrangements that work both for the organisation and for staff within it to create a culture in which people feel supported.

Other leads

7.2.23 For some people an executive or non-executive director may feel too senior to approach. There were suggestions that staff should be able to raise concerns with:

- a nominated manager in each department – some contributors thought it would be easiest for staff to speak to a manager in their own department who was not their line manager; but they also wanted access to someone in another department if for any reason they felt unable to speak to their own nominated manager
- an independent external organisation such as a helpline or advisory service. As shown in 3.2 our staff surveys did not indicate that external helplines are a key source of advice for staff but they clearly do have a role to play. These should be given parity with internal mechanisms in internal whistleblowing policies.

Case study: The Whistleblowing Helpline

The Whistleblowing Helpline, commissioned by the Department of Health, provides confidential information and advice on whistleblowing to people in the NHS and social care. The service is provided free of charge by specially trained advisors. Callers often report feeling isolated, worried and stressed.

The Helpline provides advice to individuals at all stages of their 'whistleblowing journey;' from those thinking about speaking up to those who have suffered as a result. They also provide training, support and advice to managers (see case study in paragraph 7.1.13) and organisations who want to be better at receiving concerns.

Counselling and support

7.2.24 Contributors described situations where they did not feel supported by their organisation after they had raised a concern. We heard examples of individuals feeling isolated and disconnected from their colleagues, sometimes through suspension or enforced special leave during an investigation, leading to a loss of confidence in their skills and a lack of self-worth. Frequently the same people reported depression, anxiety and long-term sickness absence. There were even some harrowing accounts of contemplated or attempted suicide. It was not uncommon for contributors to mention post-traumatic stress disorder and on-going problems with their health and well-being after raising a concern. Such problems were not limited to the person raising concerns, but could also affect the subject of those concerns and the team(s) around them.

7.2.25 Evidence seen by the Review indicates that psychological damage is a foreseeable risk of not treating staff correctly when concerns are raised. Recognition of the psychological impact on those directly and indirectly involved when a concern is raised is therefore important. Organisations have a duty of care to their staff. It is essential that support is provided to people who raise concerns to help them cope with the psychological and other impacts of doing so. This should include early access to professional support and counselling if needed. NHS employees are usually able to access support through their employee assistance or support programme(s), but in some cases support was not offered or contributors had difficulty accessing it when they needed it.

7.2.26 It is important that organisations keep track of what is happening to staff who have raised a concern, considering, for example, whether any sickness leave is associated with the raising of a concern and whether they are doing enough to support them. It will also enable them to keep track of cases as an indicator of the culture in that organisation. One non-health sector representative we spoke to said that they proactively followed up staff a few months after raising a concern to ensure they were alright and were not experiencing any detriment. This approach was also supported by a whistleblowing support organisation. They recommended the introduction of a programme for monitoring progress of individuals 12 months after raising a concern and the introduction of measures that could be reported to the board and considered by the CQC and relevant regulators. This could be a role undertaken by the Freedom to Speak Up Guardian and their national network of colleagues.

Team Support

7.2.27 Trained expertise can also be valuable to rebuild and restore trust within a team after it has been through a difficult period (see 6.6 on mediation). Where there are difficult problems to address, or behaviours that need to change, it can be helpful to have an open, facilitated discussion to create shared ownership of the problem and of the solutions. It can bring considerable benefits in the longer term, and is likely to justify the resources required to make it work.

7.2.28 The aftermath of raising concerns can be traumatic not only for the person raising the concern but also for the subject of their concerns and the teams those individuals work in. Some contributors stressed the importance of working constructively at individual staff member and team levels to ascertain the facts, to improve practice, and to rebuild relationships where necessary. We saw evidence of the positive impact that team support could have when concerns had been raised.

7.2.29 This approach, like some of the reflective practice methods referred to at 5.8. can help to build strong teams, where people are able to speak openly to improve patient safety, without fear of reprisal.

7.2.30 However, provision of team support after a whistleblowing incident may be too late: more can be done proactively to build and maintain strong teams and potentially prevent the need for whistleblowing in the first place. Where there are conflicts within a team or group of people working together, team building, for example to increase understanding of individual learning styles, how team members cope under pressure and the 'personalities' of individuals in the team can be as effective as some of the mediation techniques described in 6.6. We heard how this might make it easier to raise concerns with colleagues in a constructive way with less chance of causing offence or people becoming defensive.

Case study: Understanding your colleagues

Someone described joining a team that focused heavily on values and behaviours. Everyone volunteered to undertake some personality and psychometric tests to learn more about how they perceive the world and make decisions.

Whilst some were sceptical at first, overall the team found it a useful way to understand their colleagues better including their preferred working styles and how they react in stressful situations. It enabled the team to look out for warning signs and provide support for each other. It also helped the team to avoid potential misunderstandings by better understanding how people tended to react in different situations.

The team also developed a set of team values and behaviours so that it was easier to challenge each other constructively if these were being broken.

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Conclusion

7.2.31 There is a need for an expert, impartial person(s) in each organisation who can advise and support staff with concerns and who has direct access to the CEO and the board when needed. I therefore strongly advise the establishment of one or more Freedom to Speak Up Guardian roles in every NHS organisation. It is essential that there is at least one person who is seen as genuinely independent, and has the confidence of, and derives his/her authority from, the CEO and the board.

7.2.32 How this is done might legitimately vary according to the particular circumstances of each organisation. Smaller organisations might need to consider whether this could be done more effectively by sharing the role with a neighbouring service – see 8.4. In some places it might be a part-time role, indeed in some more complex organisations a team of staff who work in this role part-time might be a better solution. It is essential however that this is not additional to their existing duties. Freedom to Speak Up Guardians who continue to perform their professional roles might find it easier to gain the trust and confidence of colleagues.

7.2.33 However, these Guardians should not be the only source of advice and support. NEDs, departmental managers and external organisations also have a role to play. Ultimately it will be for the board of each organisation to make its own decision on the precise model it wishes to adopt to comply with the good practice set out at the end of this section. What is important is that all staff know that wherever they work in the NHS there is a resource available to them and how to access it.

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Good practice – Advice and support for staff raising concerns

People who can support staff with concerns

- A range of people are available to provide advice and support for staff thinking of raising a concern or who have already raised a concern including:
  - a Freedom to Speak Up Guardian(s)
  - a designated non-executive director
  - a designated executive director
  - a nominated manager in each department
  - an independent external organisation, such as a helpline or advisory service.
- The Freedom to Speak Up Guardian:
  - is recognised by all as independent and impartial
  - has direct access to the CEO and the chair of the board
  - has authority to speak to anyone within or outside of the trust
  - is an expert in all aspects of raising and handling concerns
  - has dedicated time to perform this role, and is not expected to take it on in addition to existing duties
  - watches over the process, and 'oils the wheels'
  - offers support and advice to those who want to raise concerns, or to those who handle concerns
  - ensures that any safety issue is addressed and feedback is given to the member of staff who raised it
  - safeguards the interests of the individual and ensures that there are no repercussions for them either immediately or in the longer term
  - takes an objective view where there are other factors that may confuse the issue, such as pre-existing performance issues, to enable these to be pursued separately
  - identifies common themes and ensures that learning is shared
  - raises concerns with outside organisations if appropriate action is not taken by their employer
  - works with Human Resources to develop a culture where speaking up is recognised and valued
  - helps drive culture change from the top of the organisation.
- The designated non-executive director:
  - is an independent voice and champion for those who raise concerns
  - works closely with the Freedom to Speak Up Guardian to act as a conduit through which information is shared with the board
  - provides challenge to the executive team on areas specific to raising concerns and the culture in the organisation.
- The designated executive board lead:
  - oversees and reviews internal raising concerns processes
  - ensures staff feel empowered to raise concerns
  - ensures learning from concerns is shared across the organisation
  - is accountable for the treatment of whistleblowers within the organisation.

(Continued on next page)

Good practice – Advice and support for staff with concerns *(continued)*

Counselling and Support

- Staff support and counselling is accessible and available when required to all staff who have raised concerns
- counselling is offered to staff who have been suspended or are on sick/special leave following raising a concern
- organisations keep track of what is happening to staff who have raised a concern and whether they are doing enough to support them.

Team Support

- Open and facilitated team discussions, including reflective practice, are used to create shared ownership of problems and solutions
- team building exercises are used to develop and sustain strong teams where people can speak openly to improve patient safety.

Principle 11: Support

All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

Action 11.1 The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

(a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity

(b) a nominated non-executive director to receive reports of concerns directly from employees (or from the 'Freedom to Speak Up Guardian') and to make regular reports on concerns raised by staff and the organisation's culture to the board

(c) at least one nominated executive director to receive and handle concerns

(d) at least one nominated manager in each department to receive reports of concerns

(e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.

Action 11.2 All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.

Action 11.3 NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.

7.3 Support to get back to work

Introduction

7.3.1 Some individuals who have raised concerns experience severe difficulties when seeking re-employment in the health service. For some this means they are effectively excluded from the ability to work again in their chosen field because they have made protected disclosures.

> *"I lost my career and now work part-time […] on the minimum wage facing poverty in old age."*

7.3.2 There are a number of people who leave their employment, or even the NHS as a whole, as a result of a bad experience after raising a concern. Some leave voluntarily, because they have become disillusioned or unhappy in their roles. Alternatively, relationships and trust have broken down to such an extent that it is impossible for them to remain, or to be reinstated in rare cases where they were successful at an Employment Tribunal. Some may be so affected by their experience that they become alienated from their employer and find it increasingly difficult to work there. Some become unable to work after a period of special leave or sick leave has left them de-skilled or unfit.

7.3.3 In some cases a bad experience leads employees to act in a way which others may find 'difficult' or 'challenging'. This may be conduct which even an understanding and open employer will find difficult to tolerate, yet this sort of behaviour is not always intentional and can be a sign of desperation. Some employees may also refuse to accept that their concern has not been confirmed, or that it has been handled appropriately, even when others find such a refusal difficult to understand.

7.3.4 Some people move to the private sector, go abroad or change career. Others find it impossible to secure a new job. The NHS may be made up of a large number of separate employing organisations, but it is effectively a monopoly employer in many fields. This applies most particularly to clinical staff with specialist skills where the number of job opportunities are limited and the networks are strong. A non-consensual or disputed termination of employment in one part of the system often leads to exclusion from every other part, regardless of whether there is any genuine justification for this.

> *"The majority of doctors trapped in this situation [suspension] have great difficulty ever returning to clinical practice. As the NHS is a monopoly employer other avenues of employment are extremely limited."*

7.3.5 We heard from and met a number of people who were struggling to get alternative employment and were concerned that they may have been blacklisted. While the Government has taken action to deal with blacklisting relating to trade union activity, this does not address the behaviour of recruiting organisations who may, for example, have heard via the media or 'grapevine' that an applicant is a whistleblower.

> *"I have been unable to secure employment within the NHS since my dismissal as a result of what I consider to be possible 'black-listing' within my NHS Electronic Staff Record."*

7.3.6 Quite apart from the impact on individuals, most of whom were acting in good faith when raising a concern, there is a huge waste to the NHS if highly trained and skilled individuals leave the service. I consider that all NHS organisations have a moral responsibility to give every possible consideration to re-instating a member of staff who had genuine concerns and whose own performance is sound, with appropriate support and development for them and/or for colleagues as described in 6.6 and 7.2.

7.3.7 There are undoubtedly some individuals who will raise concerns in a less than tactful way or who lack self-awareness and can be difficult or even disruptive work colleagues. The issues they raise may nevertheless be very valid, and should not be ignored. If such individuals can be supported and developed so that they can be helped to establish or re-establish effective working relationships with their colleagues, this would be a better outcome for everyone.

An employment support scheme for NHS staff

7.3.8 Beyond that, I believe that there is an urgent need for an employment support scheme for NHS staff and former staff who are having difficulty finding employment in the NHS who can demonstrate that this is related to having made protected disclosures and that there are no outstanding issues of justifiable and significant concern relating to their performance. This should be devised and run jointly by NHS England, the NHS Trust Development Authority and Monitor. As a minimum, it should provide:

- remedial training or work experience for registered healthcare professionals who have been away from the workplace for long periods of time
- advice and assistance in relation to applications for appropriate employment in the NHS
- the development of a 'pool' of NHS employers prepared to offer trial employment to persons being supported through the scheme
- guidance to employers to encourage them to consider a history of having raised concerns as a positive characteristic in a potential employee.

7.3.9 All NHS organisations should support such a scheme. Doing so would send a clear signal to their staff, and to staff across the NHS that they are willing to value people who are brave enough to raise concerns. Organisations that do should be given appropriate recognition (see 7.8).

Legal protection for job applicants/ Discrimination against job applicants

7.3.10 I consider that the existing legislation under the Employment Rights Act 1996 and the Equalities Act 2010 do not give adequate redress to whistleblowers, either when they are in employment or when they are applying for new jobs. This is discussed further in chapter 9.

Conclusion

7.3.11 Organisations should take into account the good practice at the end of this section in terms of supporting staff whose performance is sound back into employment where they can demonstrate that difficulty finding employment in the NHS is related to having made a protected disclosure.

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Good practice – Supporting staff back into employment

- Employers:
  - seek to reinstate staff who have spoken up, offering training, mediation and support where necessary
  - make clear that they welcome job applications from people who have raised concerns at work to improve patient safety
  - consider a history of having raised concerns as a positive characteristic in a potential employee.
- Organisations actively support and participate in the employment support scheme (once set up) for NHS staff and former staff having difficulty finding employment in the NHS as a result of making a protected disclosure and about whom there are no outstanding issues of justifiable and significant concern relating to their performance.

Principle 12: Support to find alternative employment in the NHS

Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

Action 12.1 NHS England, the NHS Trust Development Authority and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound and who can demonstrate that they are having difficulty finding employment in the NHS as result of having made protected disclosures.

Action 12.2 All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.

7.4 Transparency

7.4.1 Transparency is a key part of an open and honest culture at individual, organisational and regulator level. The implications of confidentiality clauses for individuals and their impact on transparency, whether real or perceived, also need to be considered. The principle of transparency was highlighted by the Bristol Royal Infirmary[85] and Mid Staffordshire Inquiries[86] and has been endorsed by the Government.

Transparency for individuals

7.4.2 We saw in 6.4 the importance of feedback to individuals, and the difficulties that can sometimes arise when the need for transparency conflicts with the privacy of an individual. We also saw how some organisations are starting to share lessons from concerns across their organisations.

7.4.3 Lack of transparency and openness by organisations has been shown to be a deterrent to raising concerns. It contributes to frustration and stress for staff who have raised concerns. In the Review we have seen examples of:

- lack of feedback after raising a concern
- investigation reports not shared
- managers influencing the content of investigation reports
- investigation reports only shared in a heavily redacted form.

7.4.4 This leads to concerns about secrecy and cover-up and feelings that those managing internal procedures collude to protect the NHS hierarchy from exposure. This in turn creates:

- mistrust in investigations – sometimes based on concerns about potential conflicts of interest of those carrying out investigations; sometimes from draft investigation reports being made available to the employer but not the whistleblower; and sometimes from theories developing to fill a communication vacuum
- concern that investigations may be turned against whistleblowers.

Transparency by organisations

7.4.5 Information from reported incidents, near misses and more general concerns can help organisations to understand why things go wrong and how to stop them happening again. Single events and near misses within one organisation can too often be seen as a one off event. Boards should already be considering data on raising concerns to identify themes and trends.

Case study: Identifying lessons and sharing learning

A trust has introduced an initiative in partnership with staff, managers and trade unions.

All staff are encouraged to log an incident report every time a patient is harmed or a near miss occurs. On a weekly basis this information is collected and analysed by a multidisciplinary team who also use a number of other sources of information to identify trends, themes and areas of concern. A risk rating is applied to each reported incident.

Where areas of concern are identified and lessons can be learned, changes are made quickly. Good ideas are shared across the trust to help avoid repeating mistakes elsewhere.

The initiative has helped to identify a number of unmet training needs and by working collaboratively across professional and organisational boundaries has instilled a sense that safety is everyone's responsibility.

85 *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*: learning from Bristol, Professor Ian Kennedy, 18 July 2001
86 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013

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7.4.6 Data should also be used at a national level to identify wider learning for the NHS. The National Health Service Act 2006 as amended sets out NHS England's duty to collect and analyse information on the safety of services provided by the health service, specifically section 13R[87] states:

Extract from Section 13R

(1) The Board must establish and operate systems for collecting and analysing information relating to the safety of the services provided by the health service.
(2) The Board must make information collected by virtue of subsection (1), and any other information obtained by analysing it, available to such persons as the Board considers appropriate.

…

(4) The Board must give advice and guidance, to such persons as it considers appropriate, for the purpose of maintaining and improving the safety of the services provided by the health service.

7.4.7 The National Reporting and Learning System (NRLS) operated by NHS England currently fulfils this statutory function. The majority of reports into the NRLS come from trusts uploading incident reports from their local risk management systems, although some smaller organisations, such as GP practices, enter information directly into the NRLS itself.

7.4.8 The NRLS publishes regular summary reports for each organisation detailing the number and type of incidents reported and the level of harm that they caused. These reports are a useful way for organisations to benchmark themselves against others in the NHS. However, they do not include the raising of, and acting on, staff concerns.

7.4.9 National analysis of staff concerns could be a useful tool for identifying and sharing themes and good practice across the system. However, the vast majority of concerns will be local issues requiring local resolution. Transparency about the recording and resolution of these concerns at a local level can send positive messages to staff and patients addressing some of the criticisms about secrecy and cover up referred to above.

7.4.10 There is considerable appetite for greater transparency. Royal Colleges and organisations representing providers and managers support better data collection and analysis about staff concerns to detect and understand potential problems at an early stage within organisations and the wider system. Organisations representing whistleblowers highlighted the need for greater transparency from both trusts and regulators, arguing for information such as the number and type of concerns raised, the number substantiated, relevant litigation, and related issues such as the number of suspensions related to raising concerns to be included in annual reports. Information about anonymous concerns can also be seen as a useful indicator of the culture of an organisation, see 6.3.

7.4.11 Our analysis of 21 whistleblowing policies showed variation in terms of monitoring and reporting. The Review's researchers concluded that some organisations had not thought through, or lacked established practice, in this area. However they did find some good examples where policies explicitly stated monitoring would be based on the number and nature of the concerns raised, together with other identified indicators measuring organisational culture.

7.4.12 There is considerable value to be gained from triangulating information from different sources to identify problems and trends that need investigating. For example, exit interviews when people leave or move departments can be very revealing as people may be most honest when they are leaving.

87 Inserted into the 2006 Act by the Health and social Care Act 2012 S23(1)

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Case study: Learning from mistakes

After participating in a transparency pilot project, a trust now publishes monthly Open and Honest Care reports.

These reports cover key safety issues such as the number of falls and pressure ulcers reported, results from patient and staff experience surveys, and details of improvement programmes undertaken in the last month to help improve patient safety. They also include anonymised real-life stories, for example about how a reported patient safety incident occurred.

By publishing this alongside the monthly performance report the trust management has shown that it is willing to learn from mistakes and tackle issues in a constructive manner.

7.4.13 This can only work if trusts can be confident that regulators will respond constructively and consistently to this level of transparency. Regulators should specify their expectations for the collection and publication of this sort of data and how they will use it. There needs to be a common understanding among regulators about 'what good looks like' in terms of raising and handling concerns so that they are consistent in their judgments about organisations on this issue. We heard concerns from employers in particular that system regulators were not always clear whether to criticise or praise a trust when the volume of staff concerns increased. This needs to be addressed and is considered further in 7.7.

Transparency by regulators

7.4.14 The regulators are doing more to triangulate data.

> *"I think it's really important not to just look at what comes through formal policy, I think it is important to triangulate data to say 'What is the health of the organisation?' and where things are raised … that there is an opportunity to try and pool that information together to see if there is a rising tide of issues that are occurring."*

7.4.15 It also seemed, from our survey of regulators, that some were taking action to be more transparent. Of those that responded to questions about transparency:

- 6 of 7 noted that they publish the number of concerns raised with them by people working in the NHS
- 6 of 7 publish the number of investigations conducted as a result of concerns being raised
- 5 of 7 publish the outcome of investigations.

7.4.16 We checked the websites of a number of professional and system regulators to see whether we could easily find information about the number of concerns that were brought to their attention and the action taken as a result. While it is possible such data exists on other sites, despite our survey findings we could only find published data from one regulator. That regulator included the number of whistleblower concerns it received in its annual report.

Confidentiality clauses

7.4.17 Settlement agreements between employer and employee are commonplace in both the private and public sectors. Such agreements are usually entered into because it suits the interests of both parties to do so, for example, to avoid the risks of costly and protracted legal proceedings or to draw a line under an employment dispute. Employees are entitled to a small sum to enable them to seek legal advice on the terms and content of the agreement.

7.4.18 Settlement agreements often contain clauses on confidentiality. This is not unique to the NHS. These clauses can be used legitimately, for example to protect commercial interests or patient confidentiality. Where used appropriately they can be an acceptable mechanism to protect the interests of both employer and employee. However, any clause written into a contract or settlement agreement that attempts to prevent a protected disclosure being made is unenforceable and is void in law[88].

7.4.19 Often confidentiality clauses are drafted in complex legalistic language and such agreements are often made at times of particular stress and anxiety for the member of staff involved. I have heard of the 'chilling effect' such clauses can have. It is not surprising that misunderstandings arise about the meaning and scope of these obligations. Individuals may also be anxious about the potential financial consequences of non-compliance with a confidentiality clause. If there is any uncertainty about its meaning it may be thought that the risk of being sued for breach is not worth taking even if public interest concerns remain.

7.4.20 I have not seen any recent settlement agreements which are not strictly compliant with the requirements of the legislation. This is consistent with the findings of the National Audit Office report in June 2013[89] which examined a sample of 50 settlement agreements, including 12 relating to health cases. It found no examples of confidentiality clauses restricting people's rights under the 1998 Act. This report was also in line with the findings of a union we spoke to that had considered a significant number of such clauses for members. All the clauses it had considered had been legally sound and had not sought to 'gag' staff on issues of public interest.

7.4.21 However, I have seen some which seem unnecessarily draconian or restrictive, for example, banning signatories from disclosing the existence of a settlement agreement. It is also clear that there is an atmosphere of fear and confusion surrounding the obligations of confidentiality in such agreements so as to make them a deterrent against public interest disclosures even where they do not have that effect in law.

7.4.22 The Mid Staffordshire NHS Foundation Trust Public Inquiry Report[90] recommended that 'gagging clauses' or non-disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners where they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care. The Secretary of State for Health made a statement in March 2013 and personally wrote to NHS Trusts informing them that 'gagging clauses' would be banned in the NHS. That in itself may have caused some confusion. For some individuals it reinforced their belief that they had been gagged and could be sued if they discussed outstanding matters of patient safety with an appropriate regulator. Others thought it meant that all confidentiality clauses would be banned, not just those that were not compliant with the 1998 Act.

Contributors' experience of confidentiality clauses

7.4.23 Confidentiality clauses were not frequently referred to by contributors to the Review, although a few individuals suggested that they had been asked to sign such agreements.

> *"Against NHS guidelines, the Trust asked me to sign a confidential gagging clause […] which stated I was at fault and would not speak out again. They said it was highly confidential between me and […]. When I refused to sign, the trust said in that case there would have to be a disciplinary case against me."*

7.4.24 Concerns from contributors included that confidentiality clauses might:

- prevent one side having a right of reply
- be entered in to without the original concern they raised being addressed
- give an impression that no-one has been held accountable

88 Public Interest Disclosure Act 1998 Section 43J: (1) Any provision in an agreement to which this section applies is void in so far as it purports to preclude the worker from making a protected disclosure. (2) This section applies to any agreement between a worker and his employer (whether a worker's contract or not), including an agreement to refrain from instituting or continuing any proceedings under this Act or any proceedings for breach of contract
89 Confidentiality clauses and special severance payments, National Audit Office, June 2013
90 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013

- give the impression that people's silence is being bought or failure is being rewarded with secret pay-offs
- prevent a future employer or a regulator from knowing if someone has been responsible for bullying or victimising a whistleblower – there were concerns that this might impact on the workings of the Fit and Proper Person Test.

7.4.25 At our seminars, there was a strong view that any clause that prevented the NHS from learning about poor practice should not be allowed. Some participants also suggested that organisations should not be able to bind people who speak up with any type of confidentiality clause. Both views are wider than the scope of the current statutory prohibition. The generally held view appeared to be that confidentiality agreements were not a good solution, almost never in the public interest, and surrounded by confusion.

7.4.26 The excessive use of confidentiality clauses of any type in settlement agreements is a hindrance to transparency. I question, for example, whether it is in the public interest for an employer to sign a confidentiality agreement relating to a performance issue involving a senior employee if that enables them to move to another public sector post, possibly on promotion. I therefore suggest that NHS organisations, and the lawyers who advise them, should take great care to ensure that any confidentiality clauses are drafted in a way that is easily understood by both parties and are genuinely in the public interest. A good starting point would be that any confidentiality clauses need to be justified rather than including them automatically.

Conclusion

7.4.27 Transparency and openness is being encouraged throughout the NHS in a variety of ways, including through the statutory duty of candour referred to in 2.3. Whilst monitoring of whistleblowing appears to be underdeveloped, it is clear that it is possible to triangulate existing data and configure indicators which can be published in the interest of transparency and learning.

7.4.28 Transparency is important for raising concerns. It helps to:

- foster the understanding that concerns are the norm, and not something to be hidden (see 5.3)
- send a signal to staff that the board welcomes and values their concerns as a source of learning (see 5.7)
- create trust and confidence that concerns will be looked into and addressed (see 6.4)
- contributes to fair accountability (see 7.5)
- improve safety within an organisation and across the NHS by sharing learning which may enable common themes to be identified as described in this section.

The Government in its response to the 'Whistleblowing Framework Call for Evidence[91]' has endorsed greater transparency and is committed to introduce a duty on prescribed persons to report annually.

7.4.29 For these reasons I advise that all organisations which publish Quality Accounts, or equivalent, should be required to include in them quantitative and qualitative data about formally reported concerns including the volume and a brief summary of what action was taken and the outcome, subject of course to constraints of patient confidentiality and data protection. I strongly advise Monitor, CQC, NHS TDA and NHS England to consider and specify, in consultation with the National Learning and Reporting System (NLRS) how much detail is reasonable and useful.

7.4.30 This information should be shared with the NRLS, the relevant regulator and commissioner(s) and the Independent National Officer (INO) (see Principle 15) assuming my advice in 7.6 is accepted. The information should be used by all organisations to identify themes that emerge from the reports and to share learning and best practice across the NHS.

7.4.31 Careful thought should be given to the need for confidentiality clauses in settlement agreements to ensure that they are proportionate and in the public interest.

91 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014

Good practice – Transparency

Transparency for individuals (see also good practice on investigations 6.4)

- The findings of any investigation are shared with the person who raised the concern and any other staff involved, redacting or editing only what is essential to respect the confidentiality of other individuals involved.

Transparency by organisations

- NHS organisations:
  - collect and analyse information related to staff concerns and triangulate it with information from other sources to help identify trends for further investigation and learning to share
  - publish in Quality Accounts (or equivalent) quantitative and qualitative data about formally reported concerns such as number of concerns raised, action taken and outcome, taking into account patient confidentiality and data protection
  - share information about formally reported concerns or incidents with disputed outcomes with the NRLS, INO (see Principle 15) and relevant regulators and commissioners.

Confidentiality clauses

- Confidentiality clauses are:
  - not automatically included in settlement agreements
  - approved by the CEO to confirm they are consistent with the public interest in transparency when used
  - written in plain English.

Principle 13: Transparency

All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

Action 13.1 All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

Action 13.2 All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.

Action 13.3

a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.
b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.
c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.
d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.

7.5 Accountability

7.5.1 Everyone should be held accountable for their behaviour and practice when raising, receiving and handling concerns where this is not consistent with the values of a well-led organisation. This applies to those raising concerns as well as the managers and leaders handling concerns.

Accountability of managers and leaders

7.5.2 The need for accountability of managers and leaders was a common theme among those aggrieved by their treatment after raising concerns. There were two main issues that contributors raised:

- managers should act on concerns and be held to account if they failed to do so
- senior managers who took action, condoned or failed to prevent action against people who raised concerns should also be held to account.

A small number even wanted to see criminal and custodial sentences.

> *"From my perspective the fundamental problem is a lack of accountability for the people who whistleblowers complain about and the managers (often the same people) who have responsibility for these problems."*

> *"Accountability is meaningless when it means only describing what has been done, rather than taking responsibility for its consequences."*

7.5.3 The overall experience of those who contributed to the Review, real or perceived, was that there was no accountability in their own cases or in cases in general.

> *"The likelihood of those who victimise whistleblowers being held to account appears close to vanishing point."*

> *"NHS staff at the 'coal face' bear the brunt of questioning when patient safety issues are raised, whilst managers, many of them senior, evade questioning or accountability."*

7.5.4 Lack of accountability has an impact in several ways:

- it acts as a deterrent for other staff with concerns, that is to say, if no action was taken against those who victimised or discriminated against staff who had raised concerns others will not come forward with information that might protect patients from harm
- it can impact on a person's personal resolution and ability to move on emotionally especially when the senior leaders involved remain employed in the health service or are promoted
- it contributes to staff not feeling valued and offends people's innate sense of fairness.

> *"Repeatedly we hear of unaccountable managers protecting themselves and undertaking biased investigations, character assassination, lengthy suspensions, disciplinary hearings which resemble kangaroo courts and ultimately dismissal of staff who previously had exemplary work records."*

> *"Unless the management, including those at the highest level, are held accountable for any harm caused by not acting on things which have been reported…, then there is little or no chance of people being willing to report things. By accountable, I mean financially or criminally liable, not just a bit of public hand-wringing by way of a press release saying how sorry they are to patients/relatives and that 'lessons have been learned'."*

7.5.5 A number of the contributors suggested that if people were seen to be held to account this would send a powerful and positive message to other staff.

7.5.6 However, there is another side to this which must be considered. Managers are just as vulnerable as other staff to the effects of the culture in which they work, and the pressures which are imposed on them. As stressed by some employers and their representatives a 'just' culture is equally as necessary for managers and leaders as it is for staff raising concerns. The consequence of an uneven approach could be a worsening blame culture for staff and a loss of talented managers from the NHS.

Role and responsibility of the board

7.5.7 Primary responsibility for ensuring that there is no victimisation or retaliation against staff who raise concerns must of course rest with the leadership of the organisation. It is for trust boards to take the lead in this, demonstrating by example the constructive and non-judgmental approach they expect staff to adopt. Getting this right should be an integral part of every board's routine responsibilities, and they should expect to be held to account for delivering on this.

7.5.8 Part of embedding the right attitudes and behaviours throughout an organisation includes making it clear that there will be consequences for those who do not abide by them. Even where the board and senior managers are fully and genuinely committed to an effective whistleblowing policy, it does not always appear to follow through to the middle managers and others who actually receive and deal with concerns.

Role of regulators and others with an oversight or monitoring function

7.5.9 System regulators and others with responsibility for oversight and monitoring of trust performance should look for evidence of these responsibilities being taken seriously and effectively discharged. We heard some optimism from contributors about the evolving role of CQC and the hope that this might bring with it a mechanism for increased accountability for those organisations and senior leaders that victimise or retaliate against staff raising concerns or take no action to stop this.

7.5.10 The handling of staff concerns will feed into the CQC's inspection regime through its well-led domain and there will be both pre-inspection data collection and analysis and onsite inspection work related to staff concerns. The CQC told us that inspection teams will consider:

- whether the value of staff raising concerns was recognised by both leaders and staff
- if appropriate action is taken as a result of concerns raised.

7.5.11 My proposals for more coordinated actions by system and professional regulators are set out in 7.7 and Principle 16.

Regulation of managers

7.5.12 Some NHS workers and some organisations who contributed to the Review consider there should be some form of statutory regulation of managers. They called for parity with doctors and nurses or at least assurances that managers complied with their relevant professional codes.

7.5.13 As noted in the Mid Staffordshire NHS Trust Public Inquiry Report,[92] the professional accountability faced by healthcare professional staff is of a different order to that applicable to managers. There was acknowledgement in written contributions and at the seminars that the duty of candour and the Fit and Proper Person Test (FPPT) for directors or their equivalents of health service bodies described in 2.3 might go some way to improve accountability. There were even suggestions that the FPPT should be extended to other senior positions, not only director level posts.

7.5.14 The FPPT requires that, among other things, directors should not have 'been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity'. Overall, there was uncertainty about whether these regulations would make a difference given that there were still questions about how the arrangements would work in practice. This needs to be kept under review.

92 *Mid Staffordshire NHS Foundation Trust Public Inquiry*, Robert Francis QC, 6 February 2013

7.5.15 Whilst I do have sympathy with those who seek a system of regulation for managers, comparable to that applicable to registered professional clinicians, I am not convinced that the time is right for this step. Individuals cannot be recruited to senior positions without satisfying the FPPT. Boards and CEOs should look at applicants' records in respect of people who have raised concerns when assessing whether they satisfy this test. It is important to see if the FPPT has the desired effect first. However, whilst I consider it prudent to give this test a chance to bed down as it only came into force at the end of November 2014, I do think more can be done to enhance the protection of NHS workers making protected disclosures. As noted above, my proposals for more coordinated action by national regulators are set out at 7.7 and Principle 16.

Personal accountability of those who raise and who handle concerns

7.5.16 Personal accountability should apply to an individual who decides to raise a concern as well as managers handling the concerns.

7.5.17 If it is not already so regarded, discriminating against, or victimising, an NHS worker because they have raised a concern, or turning a blind eye when other officers or employees do so, should be regarded by employers as 'serious misconduct or mismanagement'. Individual members of staff need to understand that they will be held personally accountable for such behaviour. If they do not already do so, all relevant policies should be clear that victimisation, or allowing the victimisation by others, of someone because they have raised a concern will result in disciplinary action. Clearly the nature of that action, and any subsequent sanction, is a matter for local discretion having regard to the facts of individual cases.

7.5.18 The vast majority of people who feel compelled to raise concerns do so out of a desire to protect patients and improve quality of care. However, we also know that there is a small minority of people who knowingly raise false concerns or who raise concerns for less honourable reasons. This was discussed in 5.3. Staff have both a professional and personal responsibility to be honest and reasonable in raising concerns and considering the response to their concerns.

7.5.19 All NHS staff, regardless of their seniority, have a responsibility to behave in a way that shows respect for their colleagues. We heard too many anecdotes about unacceptable rudeness by one colleague to another which can be intimidating and discourages people from raising concerns. Such behaviour should be seen as a safety issue and should not be tolerated. Those who continue to behave in this way should be held accountable, whether or not they have raised bona fide concerns.

Conclusion

7.5.20 Everyone should expect to be held accountable for their behaviour and actions. This includes those who are responsible for, or contribute towards poor practice, or any other behaviour which discourages people from raising concerns or if they victimise them for doing so. It also includes anyone who raises a concern not believing it to be true or at least worthy of investigation such as a vexatious complaint against a colleague.

7.5.21 Under Principle 1, a board's progress in creating the right culture for people to speak up will be considered as part of the assessment of whether the organisation is well-led. Individuals and boards also need to be, and be seen to be, accountable for what happens in their organisations about raising concerns. The FPPT should be used in this context. Boards have a clear role in establishing the right culture and demonstrating what is and what is not acceptable. Failure to do so, or even worse, condoning or ignoring departures from what is acceptable or considered to be good practice in relation to raising concerns, should be taken into account in any assessment of who is a fit and proper person.

7.5.22 Speaking up should always be done respectfully. Disrespectful behaviour of one colleague to another is never justified, even if it involves raising a concern. This should be regarded as a safety issue. Those who are continually disrespectful should be held accountable.

Good practice – Personal and organisational accountability

- Everyone working in an NHS organisation is held accountable for their behaviour or practice. Poor behaviour is inconsistent with the values of a well-led organisation.
- All staff who raise concerns:
  - do so in good faith and in a way that is sensitive to their colleagues and employers
  - have respect for the outcome of an investigation where it has been carried out in line with good practice.
- Discriminating against, or victimising, an NHS worker because they have raised a concern, or turning a blind eye when other officers or employees do so, is regarded as serious misconduct or mismanagement.
- Whistleblowing, employment and Human Resources policies are clear that victimisation, or allowing the victimisation by others, of someone because they have raised a concern will result in disciplinary action.
- Boards:
  - demonstrate by example the constructive and non-judgmental approach they expect staff to adopt
  - have regard to evidence of poor conduct against staff that have raised concerns by anyone they are considering appointing to a senior position.
- Regulators:
  - look for evidence of boards taking their responsibilities related to staff concerns seriously
  - consider the participation in, or permitting of, behaviour or practice that is inconsistent with the values of a well-led organisation by a director or equivalent, in any consideration of whether they are a Fit and Proper Person.

Principle 14: Accountability

Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them**
- **the victimisation of workers for making public interest disclosures**
- **raising false concerns in bad faith or for personal benefit**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns**
- **inappropriate use of confidentiality clauses.**

Action 14.1 Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.

Action 14.2 Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.

Action 14.3 All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.

7.6 External review

Introduction

7.6.1 This section considers two issues:

- whether there is a need for a 'body' to carry out external review of individual staff concerns
- whether there is a need for a 'body' to carry out external review of the process of handling an individual staff concern and any detriment experienced.

An independent body to consider concerns

7.6.2 There was considerable discussion in the written contributions about the potential role of an independent body to manage disclosures by whistleblowers. Some contributors were supportive of this option, others were unsure but thought it at least worthy of consideration. Most of the reasons given in support of this idea were related to mistrust of managers and internal processes which led to concerns that treatment of whistleblowers would be biased and prejudicial.

> *"Trusts cannot be left to mark their own homework."*

7.6.3 We were also told about the risks associated with establishing such a body. In particular, removing responsibility for dealing with the concern from local level to a more remote organisation could create delays, affect local ownership of issues, and require the establishment of potentially bureaucratic systems to allow the external organisation to investigate concerns. Equally importantly, there would be a real risk that serious patient safety issues may not be addressed sufficiently quickly locally, if someone reported them to an external body for investigation rather to their own organisation.

7.6.4 These risks seem to me to be powerful arguments. It is certainly not my intention to propose anything which could in fact make the practical handling of patient safety concerns more complex rather than less so. I am therefore not minded to propose establishment of an external body to consider and investigate concerns. Primary responsibility for investigating concerns should remain with the local organisation taking into account the good practice set out in 6.4.

An independent body to review local handling of concerns

7.6.5 It became apparent during the course of the Review that there is a gap in the mechanisms for oversight of how an NHS body deals with concerns raised by staff. The Government concluded in its response to the 'Whistleblowing Framework Call for Evidence[93]' that since neither the Employment Tribunal nor the legislation specifically deal with concerns raised that: 'the regulators are ultimately viewed by the whistleblower as the solution to addressing their concerns. This expectation of the 'prescribed persons' role is often not lived up to leading to a lack of confidence in the role of these bodies.' I therefore believe there is merit in having a mechanism for external review of how concerns have been handled at local level and the impact on the individual where there is legitimate cause for concern.

7.6.6 CQC can investigate through inspection whether a registered organisation is safe and well-led. In doing so it can take into account any deficiencies it finds in relation to the treatment of whistleblowers and systems for addressing concerns in general. Monitor and the NHS TDA can then direct trusts to correct systemic issues identified.

7.6.7 In addition, as prescribed persons for the purposes of the 1998 Act, CQC, Monitor and the NHS TDA are expected to take action on protected disclosures made directly to them. They can, and do, investigate, and if necessary intervene, if they are made aware that there may be on-going risks

93 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014

to patient safety that have not been adequately addressed. However, such interventions would not generally consider how an organisation managed any local investigation of a staff concern or review it to see if it was properly carried out. Nor would they necessarily look at how the person who raised the concern or others involved in it had been treated. The focus would generally be on systemic patient safety issues to resolve, and whether the NHS body had breached the terms of its regulatory obligations.

7.6.8 None of these bodies really has a remit to consider the process by which a specific concern was handled, or to consider the treatment of an individual member of staff after raising a concern. The Parliamentary and Health Service Ombudsman (PHSO) has the power to look at certain aspects of maladministration relating to the handling of concerns but cannot look at the employment or personnel aspects, that is to say the way an individual was treated by their employer after raising a concern.

7.6.9 This means that the only route by which an aggrieved member of staff can seek redress for ill-treatment or discrimination as a consequence of raising a concern, other than through the organisation's internal grievance process is to take a claim to an Employment Tribunal and navigate the multiple complexities of the 1996 Act. It was clear that contributors did not think this a satisfactory solution, either for individuals or for employers. Often whistleblowers do not want to take legal action – the great majority just want to be assured that patients are safe and get on with their jobs. Legal action also diverts attention and resources of employers away from the care of patients to defending themselves.

7.6.10 The deficiencies in the way concerns are investigated, and subsequent victimisation of individuals have been addressed in 6.4 and 7.5 respectively. What seems to be missing is any sort of external review mechanism, not to take over investigation of the concerns, but to provide a non-legalistic option to review what has been done locally, and make recommendations for further action as appropriate. This is to be compared with the more legalistic position adopted with regard to whistleblowers in the financial sector in the USA by the Securities and Exchange Commission through its Office of the Whistleblower. Under the Exchange Act 1934 section 21F1 the Commission takes action against companies which discriminate against those who provide the Commission with information. In June 2013 the Commission took enforcement action against a company requiring it to pay $2.2million to settle charges of retaliation[94]. While I do not see the need to go as far as this, certainly at this stage, I do see a need for some form of external review mechanism.

Independent National Officer

7.6.11 To achieve this, I propose that an Independent National Officer (INO) should be jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England, so that it is clear that the officer operates under the combined aegis of these bodies.

7.6.12 The INO should be authorised by these bodies to use his/her discretion to:

- review the handling of concerns raised by NHS workers where there is cause for concern in order to identify failures to follow good practice, in particular failing to address dangers to patient safety and to the integrity of the NHS, or causing injustice to staff
- to advise the relevant NHS organisation, where any failure to follow good practice has been found, to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it make a direction requiring such action. This may include:
  - addressing any remaining risk to the safety of patients or staff
  - offering redress to any patients or staff harmed by any failure to address the safety risk
  - correction of any failure to investigate the concerns adequately

94 *2012 Annual Report to congress on the Dodd-Frank Whistleblower Program*, Office of the Whistleblower, November 17 2014

- correction of any non-compliance with good practice identified
- appropriate recognition of the contribution of the worker who raised the concern to improving patient safety and quality of care
- suggesting support and remedies for former employees including referral to the employment support scheme to get staff back to work referred to in 7.3 and Principle 12
- act as a support for Freedom to Speak Up Guardians referred to under Principle 11
- offer guidance on good practice about handling concerns
- publish reports on the activities of the office, including any findings in relation to non-compliance with good practice, advice offered, and recommendations for action.

7.6.13 I want to emphasise that I am not proposing an office to take over the investigation of concerns. As I have already said, this needs to remain the responsibility of the local organisations. Nor is it my intention that this officer should be, or become, a means to circumvent existing authorised processes for raising and addressing concerns where these have been used fairly and appropriately. Where an individual has genuine fears about using their local structures to raise concerns I have made clear elsewhere in this report that local procedures should always include arrangements that encourage staff to use other options such as the range of prescribed persons. The INO should not be tasked with reviewing, let alone investigating, historic cases.

7.6.14 This new INO is someone who could consider how a case was handled, including any negative impact on the individuals concerned. Individuals could go to the INO where they have raised concerns through the proper processes and:

- have evidence or reason to believe that how their concern has been handled or the way they have been treated is not in line with the good practice as set out in this report and eventually the standard policy and practice recommended under Principle 2 Action 2.1; and/or
- are worried that the safety or other issues raised have not been properly addressed and are unable to resolve this locally. It is not, however, a means of appeal for the results of an investigation that an individual disagrees with.

7.6.15 It is not my intention that the INO should have binding powers. I do not see this role as strictly comparable to that of an Ombudsman. Instead they would advise relevant organisations on any actions that should be taken to deal with the issues raised. The officer would need to operate in a timely, non-bureaucratic fashion, with the capacity to act quickly in the event of serious safety issues coming to light. He or she would need to have sufficient authority to ensure that reviews and any recommendations coming from them are taken seriously and acted upon quickly.

7.6.16 The intention of my proposal is to provide an officer with the widest discretion to decide whether or not it is appropriate to become involved in a particular case, and, if so, what measures of intervention may be appropriate. Thus in one case the INO may decide to recommend to an employing trust that it arrange for an independent investigation of a concern. In another he/she may suggest that some form of mediation is attempted to repair fractured relationships. In a third it may be decided to signpost advice or guidance in an organisation's policy and procedure. In a fourth he/she may suggest that the treatment of a person who has raised a concern justifies either the organisation, or another stakeholder offering discretionary support.

7.6.17 The INO would in essence fulfil a role at a national level similar to the role played by effective Freedom to Speak Up Guardians locally. They would not take on cases themselves, but could challenge or invite others to look into cases which did not appear to have been handled in line with good practice or where it appeared that a person raising a concern had experienced detriment as a result of raising the concern. The INO could also provide a resource for the system as a whole by supporting Freedom to Speak Up Guardians and by offering guidance on good practice informed by developing experience from the cases considered.

Principle 15: External Review

There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this Report, namely:

- **review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is cause for believing that this has not been in accordance with good practice**
- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect**
- **act as a support for Freedom to Speak Up Guardians**
- **provide national leadership on issues relating to raising concerns by NHS workers**
- **offer guidance on good practice about handling concerns**
- **publish reports on the activities of this office.**

Action 15.1 CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post might jointly be created and resourced and submit proposals to the Secretary of State as to how it might carry out these functions in respect of existing and future concerns.

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7.7 Coordinated regulatory action

System regulators

7.7.1 Primary responsibility for ensuring that there is no victimisation or retaliation against whistleblowers rests with the leadership of the employee's organisation. There is legislation which provides a remedy if someone is victimised but as noted in chapter 9 it is perhaps not as effective as it could be in providing protection. One thing that is missing is any substantive protection offered by the system regulators to the individual member of staff who raises a concern. I have addressed this in 7.6 where I propose the creation of an Independent National Officer (INO).

7.7.2 I believe there is scope for the system regulators to play a bigger role in supporting staff who raise concerns. I recommend that they do more to exercise their powers to take regulatory action against any registered organisation that does not handle concerns, or the individuals who raise them in line with the good practice set out in this report. This should include protecting those who raise concerns directly with a regulator, as well as those who have difficulties with internal disclosures.

7.7.3 As set out in 7.5, this is most likely to be observed by the CQC, either as part of their normal inspection process or as a result of someone raising a concern directly with them. CQC inspections should involve discussions with the organisation and with staff about how they deal with and handle workers raising concerns and what they are doing to ensure they have the right culture. They should also consider the particular treatment of staff who may be more vulnerable after raising a concern such as locums, agency and bank staff, students, trainees and staff from black and ethnic minority backgrounds – these groups are discussed in more detail in chapter 8. Where the CQC is not satisfied that appropriate processes and protection have been provided they should take regulatory action or, if appropriate, require either Monitor or NHS TDA to do so.

7.7.4 It is essential that system regulators adopt a consistent approach and respond in a proportionate manner to issues raised. Employers' representatives expressed frustration at what they described as 'regulation gone mad' with similar information being requested by each regulator and inconsistent approaches taken as to judgements made on that data. I propose that the CQC, Monitor and the NHS TDA, in consultation with the Department of Health, work together to agree procedures and define the roles they will each play in protecting workers who raise concerns in relation to regulated activity.

Professional regulators

7.7.5 There is an important role for the healthcare professional regulators to play in preventing victimisation of whistleblowers. For example, they could set out requirements for support for trainees and students raising concerns.

7.7.6 From the contributions we received it is clear that there is considerable concern amongst, nurses, doctors and other healthcare professionals that referrals to their professional regulators are sometimes made in retaliation for blowing the whistle. Contributors also told us that Fitness to Practise (FtP) hearings often do not consider the possibility that it could be a retaliatory referral, and the relevance of the concern that they had raised is generally not considered. As a result individuals can feel unsupported by their professional regulator. Some professional regulators recognise that they need to do more to support staff who raise concerns. For example, the General Medical Council has launched a review of its own processes, which I welcome. It is chaired by Sir Anthony Hooper and is looking at how doctors who raise concerns are treated by the GMC and how best they might be supported in future.

> *"Standing up for what you believe in is important, and nowhere is that more true than in healthcare. Our guidance is quite clear about the requirement of doctors to raise concerns about poor care, but we want to make sure we are doing all we can to support those that do."*[95]

95 *Press Release: Sir Anthony Hooper to undertake GMC whistleblowers review,* General Medical Council, 5 August 2014

7.7.7 There was concern about the length of time it takes to screen concerns reported to professional regulators and to undertake FtP investigations. This was acknowledged in the Professional Standards Authority for Health and Social Care's (PSA) 2013-14 annual report[96] which said that four regulators 'did not ensure that their FtP cases were progressed without undue delay' and another was likely to be in the same position in 2014-15 if 'it continued to decline'. The reasons varied across the regulators and were set out in their individual reports.

7.7.8 The PSA noted that failure to progress cases promptly could: lead to risks to patient safety (unless an interim order is put in place); have an adverse impact on the quality of the evidence that is available at the final hearing; and/or cause unnecessary distress to all those involved, as well as damage confidence in the regulator.

7.7.9 We also heard concerns about lengthy suspensions while awaiting the outcome of a fitness to practise review. Professional regulators should review the length of time it takes to screen and undertake FtP reviews with a view to speeding up their processes. The issue of suspensions is considered in 6.5 where I advise that suspensions should be a last resort.

7.7.10 It is important that professional regulators ensure that they are aware of the context in which a referral has been made. I am not suggesting that whistleblowers should be immune from Fitness to Practise procedures. There may be a perfectly good justification for a referral. However it is important that the professional regulator is aware of material background facts, to enable them to judge whether they are relevant, and whether there is any risk of it being a retaliatory referral or unfair in any way. The important question is whether other staff in that organisation have been, or would have been, treated in the same way in the same circumstances.

Conclusion

7.7.11 There is scope for better co-ordination between the systems regulators to provide greater protection for NHS workers who raise concerns. CQC, Monitor and NHS TDA should work together in consultation with the Department of Health and the new Independent National Officer (INO) to define their roles and agree procedures to enable this to happen.

7.7.12 Healthcare professional regulators should review their procedures and processes in line with the good practice described at the end of this section. They should also consider reviewing how to ensure that their screening processes and reviews of FtP take place as quickly as possible and take into account the possibility of retaliatory referrals.

7.7.13 I would consider the following to be good practice for professional regulators.

Good practice – Professional regulators

- Professional regulators:
  - co-ordinate with each other and system regulators to share information and act on it appropriately
  - check whether the registrant about whom a concern has been raised has made one or more protected disclosures in connection with their employer's or healthcare professional's service and consider any relevance of such matters to the issues referred to them
  - carry out screening of referrals and any resulting fitness to practise reviews as quickly as possible
  - treat facts related to a protected disclosure as a relevant matter in their deliberations, satisfying themselves that the individual has been treated fairly and in line with others in the same organisation.

96 *Annual Report and Accounts and Performance Review Report 2013/14,* Professional Standards Authority for Health and Social Care, 2014

Principle 16: Coordinated Regulatory Action

There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

Action 16.1 CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.

Action 16.2 Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.

7.8 Recognition of organisations

7.8.1 Just as there is a need for recognition of individuals who raise concerns (see 5.7), organisations which encourage an open and just culture in which staff feel free and supported to raise their concerns should also be celebrated The Government has said in its response to the 'Whistleblowing Framework Call for Evidence[97]' that it intends to identify and celebrate organisations which have embraced a culture of whistleblowing. This is welcome and should show others the value it brings and help drive cultural change.

7.8.2 It might be possible within the NHS to devise some financial incentive to organisations for outstanding practice in this area or for CQC to take this into account in its ratings assessments. Either of these measures would be likely to encourage good practice, but use of CQC ratings would be easier and probably less complex to implement. An annual award for the NHS organisation that can demonstrate the best patient safety improvement(s) achieved through staff raising concerns could also be beneficial.

Principle 17: Recognition of organisations

CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

Action 17.1 CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.

97 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014

8

Particular measures for vulnerable groups

8 Particular measures for vulnerable groups

This report has shown how difficult it can be for staff to raise concerns and the detriment that they can face if they do. What has also become clear is that some staff groups may be more vulnerable than others when they raise a concern, particularly:

- **locums, agency and bank staff** – see 8.1
- **student working towards a career in healthcare and trainees** – see 8.2
- **staff from black and minority ethnic backgrounds** – see 8.3
- **staff working in primary care organisations such as GP practices** – see 8.4

Each of these is discussed in more detail in this chapter.

8.1 Locums, agency and bank staff

8.1.1 Locum doctors, including sessional GPs, and agency and bank staff play an important role in the NHS. They are generally supplied through agencies although some GP locums may be freelance. They supplement the permanent team and help with peaks in workload. They can also help to cover planned and unplanned shortfalls in staffing including vacancies and short or long term staff absences.

8.1.2 There are a number of issues for these groups in terms of raising concerns:

- they may have no formal induction and therefore may not know where and how to raise concerns
- they may lack support if they have concerns
- they may fear that they will not be employed again by the organisation if they do raise a concern

> *"As an agency HCA, on a zero hour contract I feel that if I raise concerns about bad practice on a ward that I won't get any more shifts on that ward and maybe other wards in the same unit."*

- they may fear that their agency will receive a bad reference making employment elsewhere difficult.

Case study: A locum doctor whistleblower

A locum doctor raised concerns about the way the ward in which he was contracted to work was run and about the performance of several senior colleagues. He made a number of suggestions to improve the service and the quality of care delivered.

The locum's contract was terminated early without notice. The trust alleged that a member of staff had made a complaint about the practice and behaviour of the consultant, but they were unwilling to share details of the complaint with the locum.

The trust did not refer the matter to the GMC but did provide a reference to the locum's agency that detailed the complaint about him. Since receiving this 'negative' reference, the locum has struggled to find another post.

8.1.3 Staff who work on a locum, bank or agency basis bring a valuable perspective to an organisation. In addition to the skills they are bringing in to fill the identified vacancy, they bring with them experience of a range of different environments. They may be able to share good practice and identify areas that could be improved both while they are working and at exit interviews, if they take place.

8.1.4 There is a responsibility on locum, bank and agency staff raising concerns, as there is for permanent employees, to be reasonable in both what they raise and how they raise it. It is possible that they may raise concerns because things are done differently to other organisations where they have worked. Of course different does not mean wrong. The key, as with other employees raising a concern, is to ensure that the concern is considered fairly and appropriately and an explanation given of any action that will be taken and a reason why if not. What such employees say should not be ignored because of prejudice about their status alongside an established hierarchy.

Conclusion

8.1.5 I do not think it necessary to set out specific actions related to locums, agency and bank staff. All Principles in this report should be applied to this group as it does to other employees. However, employers and agencies do need to be aware of the vulnerable position that this group can find themselves in and ensure that they receive appropriate induction, training and support, are encouraged to raise concerns and are not penalised for doing so. CQC could take this into account as part of their inspections as set out in 7.7.

8.2 Students and trainees working towards a career in healthcare

8.2.1 Students on placements run by their educational establishments are not 'workers' within the statutory definition and are not therefore protected under the Employment Rights Act 1996. On 12 January 2015 the Government laid an Order to extend the statutory definition of 'worker' so that, in future, it will include student nurses and student midwives. I welcome this. The Government also remains committed to consider other comparable groups: as I make clear in this section, such consideration is essential.

8.2.2 Whilst students are on placement they are exposed daily to real situations where they may witness incidents concerning public and patient safety. They are therefore in a particularly good position to spot things that might be going wrong. Most will bring a new perspective and an independent viewpoint when they enter clinical environments. They are a fresh pair of eyes, keen to learn and provide constructive challenge based on current learning and research. Their common sense, caring and compassionate natures are not yet dented by the scarring of previous experiences.

8.2.3 Students and other trainees working towards a career in healthcare understand that they have a responsibility to patients, the public and the profession and generally want to raise concerns where they have them. However, they can worry that raising concerns may reflect badly on them or jeopardise passing their assessments or placements. They can be deterred by the attitude of staff who are dismissive of their concerns, or even hostile. We heard many examples of poor experiences after student nurses had had the courage to speak up in such circumstances. For these individuals there had been a personal and a professional impact and, in some cases, their experience had put off their peers from raising their own concerns. This does nothing to improve patient safety.

"Students are reluctant to complain even to an arm's length body such as Health Education England because they perceive interactions and networks at all levels. They see that their actions may 'leak' widely and they feel vulnerable […] given the hierarchical structure, highly networked and status orientation of the NHS, these anxieties are not irrational."

University training and placements

8.2.4 We were told that training on raising concerns is being included within some curricula but that the level and availability of such training was variable around the country. Some universities enable students to talk through their experiences and perceptions, but it depends how the course is structured.

8.2.5 Students should not feel isolated if they have a concern or after they raise a concern. It may be that students are less isolated than some other professional groups such as locums and bank staff. They have a network of colleagues and tutors outside of the organisation in which they are placed with whom they ought to be able to discuss their concerns openly and confidently including peers and staff in educational establishments. However students, and indeed trainees, are still a vulnerable group in terms of raising concerns. For example, they are heavily reliant upon their placement supervisors/mentors for 'sign off'. We heard of student nurses:

- 'failing' placements after raising concerns when there had previously been no issues regarding their practice
- losing placements after raising concerns and ultimately losing their place at university
- suffering detriment from co-workers or managers whilst they remained in that placement.

8.2.6 Universities must make placements available for their students to provide the required standard of education, and trusts are reliant on a constant stream of students to maintain effective staffing levels. This creates pressure on both sides. Worryingly there were examples of students continually being placed in unsuitable settings. Often students were given placements in particular wards or trusts where we were told that concerns had been raised previously either by themselves or others with no evidence that those concerns had been addressed. Such placements appeared to be well known to the students, where for example 'everyone knows the ward manager is a bully'. Many feared being 'sent' to them. This is unacceptable.

Case study: The experience of a student nurse

A student nurse had concerns about the ward they were working on. They received little support despite contacting their university to ask for advice and help in raising their concern and the trust said that, because they were not an employee of the trust, they could not deal with their concern. The student attempted to raise the issues a number of other ways, but found that they were being treated as a 'nuisance'.

The student wanted to change to a different placement as they felt that the ward was not a safe learning environment. A new placement could not immediately be found so the student was placed on leave until an alternative could be arranged. This had a negative impact as they then had to make up the time they missed and were marked as having failed part of their course.

Fitness to practise

8.2.7 Some student nurses raised concerns about fitness to practise (FtP) hearings. The Nursing and Midwifery Council (NMC) investigate and, if necessary, take action against registered nurses and midwives on complaints which suggest they are not fit to practise. However, FtP hearings for student nurses are run by the university and its staff, rather than the NMC. This raises three questions:

- whether universities are adequately skilled and equipped to perform such a function
- whether universities could be biased against students due to a conflict of interest to

maintain the availability of placements in areas where they might be difficult to come by
- why student nurses should face FtP hearings in this way when other students would follow a university disciplinary process?

8.2.8 Where a student fails a nursing course they could apply to start again elsewhere. However student nurses may be disadvantaged if they have been through a FtP process after raising a concern. There is a risk of this being held against them.

Student complaints

8.2.9 The Higher Education Act 2004 required the appointment of an independent body to run a student complaints scheme in England and Wales. The Office of the Independent Adjudicator (OIA) is the organisation founded to oversee any complaints made against a university. All of the universities in England and Wales must subscribe to OIA. Its role is to review the handling of individual complaints by students against universities including complaints about the placements offered by a university – it focuses on the process rather than the merits of the case. However, the OIA has no regulatory powers over universities and cannot 'punish' or fine them. Neither does it have any locus over public interest concerns about NHS organisations or regulated healthcare professionals. Its functions are too general to be of real use in addressing the challenges with which this Review is concerned.

Protection for students working towards a career in healthcare and trainees

8.2.10 When the 1998 Act first became law, the intention was for it to include protection for 'trainees' including nurses. However as student nurses, and some other healthcare professionals, now obtain their qualifications through degree based rather than vocational courses the legislation is being interpreted by some in a way that excludes them from the protections provided for.

8.2.11 In 2014, the Department for Business, Innovation and Skills (BIS) acknowledged that the provisions in section 43k(d) of the 1996 Act may no longer offer adequate protection to student healthcare professionals and that this legislation should be amended so that student nurses would be included in the protections it affords other workers. This protection will come into force in early 2015. In its response to the 'Whistleblowing Framework Call for Evidence[98]' BIS indicated that the Government will consider whether to extend this to 'other student arrangements similar to student nurses'. In my view it is essential that the statutory protection, such as it is, is extended to include all students when on work placements studying for a career in healthcare.

How could the position of students working towards a career in healthcare and trainees be improved?

8.2.12 Student nurses we spoke to set out a range of ideas to improve their confidence in raising concerns and the support and protection needed for this. Suggestions included:
- an independent person or information service for confidential support
- feedback via a formal mechanism throughout the process after raising a concern
- protection from bullying, intimidation, gossiping and harassment directly or indirectly, including through social media, by proactive monitoring of unacceptable behaviour from co-workers or managers
- better training and support from universities in raising concerns.

8.2.13 These suggestions are similar to those we heard from qualified staff. The Principles and corresponding actions set out in chapters 5, 6 and 7 are therefore relevant. However, I believe that more needs to be done to better support our next generation of nurses and other healthcare professionals including trainee doctors.

Good Practice

8.2.14 From speaking to a range of contributors it would seem that the following should be considered good practice.

98 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014

MAHI - STM - 101 - 016508

Good practice – The role of organisations involved in education and training

Training and support from universities and other organisations

- Education and training organisations:
  - cover raising concerns in the course curriculum
  - make available at least one officer responsible for: receiving concerns from clinical students and trainees; offering advice and support; ensuring that the concern is referred to an appropriate person or organisation for investigation; and monitoring the well-being of the student who has raised the concern
  - ensure support (both practical and psychological) is provided throughout any informal or formal raising concerns process
  - ensure that students are given protected time to reflect on their placements, including when they raise concerns, and have a support network in place to help them through difficult situations.

Clinical placements

- Organisations offering clinical placements make available to clinical students and trainees the same procedures for raising concerns, obtaining advice and support and means of investigating concerns as for their regular staff.
- Providers of a clinical placement inform the responsible educational or training organisation if a clinical student or trainee makes a public interest disclosure or raises a comparable concern, unless the student has specifically asked that this is not done.

Assessments

- Educational or training organisations review any adverse assessment of the competence or fitness of a clinical student or trainee who has made a public interest disclosure or has raised a comparable concern to ensure that it has not caused or contributed to a disadvantage or detriment in an assessment.

Education and training organisations and regulators

- Education and training organisations and regulators:
  - work closely when assessing the suitability of placements for students ensuring that they are good quality placements that will add value to the clinical student or trainee working in the NHS
  - consider how credit for raising concerns that have contributed to patient safety can be given in students and trainees assessments.

Regulators

- Regulators do not validate any course/placement which repeatedly receives poor feedback or where concerns have continually been ignored.

Conclusion

8.2.15 Subject to legislation, student nurses and student midwives will shortly be brought within the scope of the 1998 Act. The Government's response to its 'Whistleblowing Framework Call to Evidence[99]' also indicated that it might considering extending the scope to 'other student arrangements similar to student nurses'. I consider it essential that the same protections are in place for all students studying for a career in healthcare – see Principle 20 in chapter 9.

8.2.16 There is evidence that support and protection for students and trainees generally is patchy and that they can fall between health education institutions, the regulators and providers of healthcare. This is addressed in Principle 18 and its corresponding actions.

Principle 18: Students and trainees

All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

Action 18.1 Professional regulators and Royal Colleges in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the principles and good practice in this report.

Action 18.2 All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns.

99 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014

8.3 Staff from black and minority ethnic backgrounds

Context

8.3.1 There are many staff from black and minority ethnic (BME) backgrounds in the health service. BME doctors tend to be over-represented in staff grades and under-represented in senior management roles. BME staff more generally are also over-represented in junior grades across both medical and non-medical staff. The 2013 Health and Social Care Information Centre Medical and Dental Workforce Census[100] showed that BME staff are under-represented in the higher Agenda for Change pay bands. In addition, 'the Snowy White Peaks of the NHS'[101] report which looked at BME issues in the NHS in London found that 41% of NHS staff are from a BME background but only 8% of trust board members, and 2.5% of chief executives and chairs.

8.3.2 In addition, 'Snowy White Peaks'[102] showed that, nationally, even once BME applicants had been shortlisted, white shortlisted applicants were 1.78 times more likely to be appointed. It was 3.48 times less likely that BME applicants would be appointed than white applicants.

Experience of BME staff raising concerns

8.3.3 Feedback from BME staff during the course of the Review raised issues that were broadly similar to those raised by other staff such as poor handling of concerns, lack of support and an overall negative experience. Whilst the issues raised and the suggested solutions did not differ greatly, I heard how vulnerable staff from BME groups can feel when raising concerns, perhaps more so than other staff groups.

> "*Most experts, leaders, decision makers are white and most staff severely punished are from BME and the NHS has to look at the reasons and what lessons can be learnt and why there are hardly any BME leaders in the decision making positions and impact of subconscious bias.*"

> "*If you are a whistleblower and BME it's a double whammy. I can tell you, whistleblowers and BME staff there are a lot of similarities in the way NHS treats them […] if a BME raises concerns about white doctors, in some trusts it is not investigated or it is dealt with informally. In some cases when BME doctors are blamed, they are immediately suspended. The BMEs are punished if a white doctor raises a simple concern.*"

8.3.4 Concerns were raised about the culture of the NHS and its informal networks which can leave some BME staff feeling excluded. We also heard examples of poor handling of cases which may or may not have been exacerbated by cultural misunderstandings.

8.3.5 This sense of vulnerability was also apparent from our staff survey – the main findings in relation to BME staff are in 3.3 and Annex Dii. Key messages, with the caveat that the numbers involved are small and therefore lack statistical rigour, were that BME staff (excluding white non-British) were:

100 *NHS Workforce: Summary of staff in the NHS: Results from September 2013 Census*, Health & Social Care Information Centre, 25 March 2014
101 *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*, Roger Kline, 2014
102 *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*, Roger Kline, 2014

- more likely to report fear of victimisation and lack of trust in the system as a reason for never having raised a concern about suspected wrong doing in the health service than staff from a white background
- more likely to report having raised concerns about harassment, bullying or discrimination than staff from a white background
- more likely to report suffering detriment such as being victimised or ignored by management or co-workers after raising a concern than staff from a white background
- less likely to report being praised by management after raising a concern than staff from a white background
- more likely to report suffering detriment as a result of supporting a colleague who had raised a concern than staff from a white background
- less likely to report a concern again if they suspected wrongdoing than staff from a white background.

8.3.6 The messages from our primary care staff survey were broadly the same although BME staff in primary care seemed to be as satisfied as staff from a white background with the response to their concern whereas in trusts, staff from a BME background were considerably less satisfied than staff from a white background.

8.3.7 There were also anecdotal accounts that BME staff are:

- likely to feel more discriminated against after speaking up
- more likely to be referred to professional regulators if they raise a concern
- more likely to receive harsher sanctions than clinicians from a white background
- likely to experience disproportionate detriment in response to speaking up if they have been trained overseas.

Conclusion

8.3.8 To the extent that BME groups feel generally vulnerable or discriminated against because of their ethnic background, they are also likely to feel more vulnerable to victimisation as a result of raising concerns than their white colleagues. Whilst it is outside my remit to address any general issue of racial discrimination or disadvantage, it clearly has implications for raising concerns. Any such detriment acts as a deterrent to speaking up and, where people are brave enough to do so, it appears to make them more vulnerable to unacceptable detriment.

8.3.9 The Principles in this report and their associated actions apply as much to BME staff as to others. I do not think it necessary to set out specific additional actions related to the raising of concerns by BME staff. However, organisations should consider the support and protection that may be required by BME staff, having regard in particular to the possibility that they may feel particularly vulnerable when raising concerns. For example, it will be important that investigators are representative of the makeup of the workforce, and have an understanding of any issues relating to minority groups. In addition, CQC could take account of the handling of concerns from staff from BME backgrounds when they consider handling concerns more generally as part of their inspections (see 7.7).

8.4 Staff working in primary care organisations such as GP practices

Introduction

8.4.1 The raising of concerns by NHS workers in primary care organisations, that is GP, dental and ophthalmic practices and community pharmacies requires separate consideration. Staff in such organisations can feel particularly isolated as it is harder to raise concerns without being identified, there can be a power dynamic in the employment relationship and a real risk to employment as they can be employed directly by the individual providing the service that is the subject of the concern.

> " *GP partners have complex relationships, unique within the NHS. There are closely shared professional roles and responsibilities, including both clinical and managerial aspects […] [and] shared financial outcome[s]. […] [There is] an expectation of total loyalty and mutual support, especially relevant in the face of outside challenge."*

8.4.2 There are also likely to be fewer options for raising concerns outside of an organisation for ancillary and non-clinical staff who are perhaps not members of a professional body or union.

8.4.3 Over 4500 people responded to our primary care staff survey. The majority (68%) were from a pharmacy background with 19% working in general practice and 13% from unspecified organisations in primary care. Allowing for the caution due to small numbers, the key messages were that:

- more needs to be done to raise awareness of whistleblowing and confidential reporting procedures within primary care organisations
- staff in primary care are more likely to take a concern outside of their organisation than staff in trusts. Lack of confidence in the process, dissatisfaction with the outcome of the internal procedure and concern about the potential impact on their career were some reasons highlighted. It might also be a reflection of the fact that there are more options for raising and escalating concerns internally within a larger organisation than in primary care
- professional organisations and health care regulators are the most likely external source for primary care staff to raise a concern with
- victimisation after reporting a concern or supporting colleagues who have raised a concern can occur in primary care. I suspect it is particularly difficult to escape owing to the relatively small size of most primary care employers.

8.4.4 The General Dental Council (GDC) shared with us results of their annual registrant survey for 2013. Their registrants include dentists and dental care professionals in the UK. Their survey covered employees in the NHS, private and mixed practice in both primary and secondary care and included questions on raising concerns. Of the 3611 registrants who responded:

- 88% would know where to go to raise a concern
- 46% had encountered at least one issue which they felt should be raised as a concern
- 39% had raised a concern within their place of work about the practice or behaviour of another dental professional
- 80% felt that they could raise concerns openly in their workplace
- 78% felt that their workplace took concerns seriously
- 72% felt their workplace was one where concerns were investigated appropriately
- 66% felt that raising a justified concern would not be held against them.

All numbers were lower among registrants who had actually raised a concern.

Raising concerns in primary care

8.4.5 Every GP practice has to have a formal process for patient complaints which is considered as part of the CQC inspection process. However, there is no requirement for GP practices to have an equivalent process for staff concerns. That is not to say that many will not have such policies in place or other mechanisms to support staff to raise concerns. Indeed we heard of some good practice in this area.

Case study: Good practice in primary care

A GP registrar told us that on arrival at the practice, she and her trainer discussed the whistleblowing policy. She was shown how to access it electronically and a copy was also placed in her personal file. The policy was to raise concerns with her trainer in the first instance but if her concerns were regarding him then there were other options such as the practice manager or which other partner she felt most comfortable with. She was informed that any concern would then be raised and documented at the practice meeting.

If she did not feel comfortable raising concerns within the practice, the trainer encouraged her to raise the concerns with her programme director on the General Practice Vocational Training Scheme (GPVTS). Her GPVTS comprises of a weekly half-day meeting where all the GP trainees within the scheme meet for clinical teaching as well as discussions surrounding difficult cases or situations. This provides an avenue outside the practice where the GP registrar can voice her concerns in a safe and secure environment. She noted that these discussions were led by the programme director who could also escalate concerns to the Local Education and Training Board with the consent of the trainee who would remain supported by the Programme Director throughout.

The GP registrar also mentioned that there were other avenues within the practice for staff to raise concerns, such as:

- a weekly Clinical Governance meeting
- a monthly practice meeting.

The GP registrar considered the weekly meetings were an opportunity to raise concerns about the quality and safety of the care delivered to their patients. She considered that there was a very open culture in the practice and the clinicians felt at ease challenging each other's decisions. However, the practice nurses did not attend these meetings. They did attend the monthly practice meeting though and she had seen instances where a practice nurse had raised concerns regarding a doctor's decision and vice versa.

Uncertainty about roles in the current landscape

8.4.6 There is considerable uncertainty for GP practices about who to advise their staff to go to if they wish to raise a concern externally. Staff concerns previously sat within the remit of the former primary care trusts (PCT).

Case study: Concern about a colleague

A GP was not clinically dangerous but was suffering from severe anxiety. This led to over investigation and over referral of patients to hospital. Colleagues were concerned. Initial action was a 'quiet word' from a colleague. When this did not resolve the situation they went to the PCT for help. The PCT was able to offer support: communication skills, counselling and mentorship support, and occupational health.

8.4.7 I was surprised at the lack of clarity that now exists for primary care staff wanting to raise a concern, particularly about who to go to for advice or to raise concerns outside of a primary care organisation.

> " *We had no template to guide us how to proceed within the practice and did not really know how to tackle it."*

8.4.8 In the recent restructuring of the NHS this responsibility does not appear to have moved from PCTs to any other body. There seems to be no formal route to follow outside of their organisation other than the appropriate professional regulator (if they have one), the CQC or the police for a criminal matter. There is considerable uncertainty about the role of NHS England, and, for GP practices, CCGs, neither of which are prescribed persons under the 1998 Act. The CQC reported seeing a slow increase in the number of whistleblowers from primary care. However, whilst it can receive and act on concerns as appropriate it is neither empowered nor resourced to support whistleblowers.

8.4.9 Options to fill the gap left by PCTs include the CCGs and NHS England Local Area Teams:

- CCGs might be an appropriate conduit for information about concerns and there are already some good CCG models led by GPs. All practices are members of a CCG but the CCG has no formal line management responsibility for them. Nonetheless, they have a statutory duty to assist NHS England in securing continuous improvement in the quality of primary medical services. This duty includes securing improvement in the outcomes of services which show their safety. However, CCGs are still in evolution. If they were to take on this role there would have to be arrangements in place to address potential conflicts of interest, for example where a concern is raised about the GP practice where the chair of the CCG is a partner. Further consideration would also need to be given to other primary care services such as dental, pharmacy and ophthalmic which do not sit within their remit.
- NHS England is an alternative. It inherited the role of performance management and oversight of the standard of service provided from PCTs but is considerably more distant in a physical sense from individual practices, and indeed other primary care organisations, than were the PCTs. It has power to remove a practitioner from the performers list and with it the power to prevent him/her providing NHS services. NHS England also provides, through a regional network, the Responsible Officers required by the General Medical Council for the oversight of revalidation of GPs in the NHS. Responsible Officers are required to act on concerns about GPs. It is open to question whether NHS England through its Area Teams and performance management teams have the capacity to deal with staff concerns, but this issue does not seem to have been addressed.

8.4.10 The role that CCGs and NHS England could play needs to be considered further. As an absolute minimum it would appear that, as commissioners of health services, both CCGs and NHS England should be prescribed persons under the 1998 Act so that staff can at least alert them to concerns and be covered by the legal protections in doing so, even if these concerns are referred on. This is covered further in chapter 9.

Support for staff in primary care raising concerns

8.4.11 Many forward looking practices are now grouping together in collaborative alliances or federations which, among other things, serve to provide infrastructure support for their members. Such arrangements could offer a structure within which a 'go to' person, equivalent to the Freedom to Speak Up Guardian role discussed in 7.2, could be provided for staff with concerns. This could provide a safe place outside the organisation for staff to approach. Federations or CCGs, on behalf of their members, could provide a home for this new 'locally owned' model for helping colleagues with concerns. An alternative, where feasible, would be an arrangement whereby the Freedom to Speak Up Guardian within a local provider trust also provides support for the local primary care organisations. Capacity, authority, and knowledge of the system may be an issue with this option.

8.4.12 It would be challenging for single-handed practitioners that do not take part in collaborative working arrangements to provide for this sort of arrangement. Dame Janet Smith in her fifth report of the Shipman Inquiry[103] remarked on the particular challenges of governance connected with small practices. I take the view that small practices should expect to share the values and aims of primary care in the NHS generally and so organise themselves that they have the facilities to do so. In the case of staff concerns, this means ensuring that there are appropriate arrangements including a facility for external support and advice about concerns.

103 *Fifth Report of the Shipman Inquiry - Safeguarding Patients: Lessons from the Past - Proposals for the Future*, Dame Janet Smith, 9 December 2004

Conclusion

8.4.13 Staff in primary care organisations should be encouraged to raise concerns openly, routinely and without fear of criticism or worse. The 2012 reorganisation of the health service appears to have left a serious gap in relation to supporting staff in primary care who want to raise concerns.

8.4.14 The Principles set out in this report should apply equally to staff in primary care. However, they will need to be modified to take into account the different structures involved. Principle 19 sets out actions that should take place. Whilst these are relevant to primary care organisations in general, they have been modelled on GP practices. It will therefore be important to consider adaptations that might be needed to take into account the different structure and organisations in dental and ophthalmic services and in community pharmacies and also relevant work already taking place in these areas. For example, the General Dental Council (GDC) informed us that they had commissioned qualitative research to look at the experiences of registrants who have raised concerns in the workplace and/or with them to examine the barriers and enablers to them doing so.

Principle 19: Primary Care

All principles in this report should apply with necessary adaptations in primary care.

Action 19.1 NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.

Action 19.2 NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.

Action 19.3 In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.

9

Extending legal protection

9.1 This chapter considers the effectiveness of the legal framework, and considers options to strengthen protection for those who raise concerns in the public interest.

9.2 We have looked at the legal framework for the protection of those who make public interest disclosures in chapter 2. The UK legislation in this field has been described as 'advanced', that is, having 'comprehensive or near-comprehensive provisions and procedures for whistleblowers' by Transparency International[104], an anti-corruption non-governmental organisation. It is often seen as an exemplar in terms of legislation on public disclosure and the relevant provisions of Employment Rights Act 1996 have been used as a template for laws in a number of countries.

9.3 In essence, where a worker makes a disclosure of a type and in a manner specified in the 1996 Act, he or she is entitled to:

- protection from a range of 'detriments', including being dismissed because of the disclosure
- a remedy if that entitlement is not respected.

9.4 The Government itself concluded in its Whistleblowing Framework Call to Evidence[105] that the whistleblowing framework in isolation does not always prevent malpractice from taking place. Nor does it encourage people to raise concerns.

9.5 Contributors who mentioned the existing legal protection were generally in agreement that it does not work well. It is complex and the concept of a protected disclosure is not easily understood. This can act as a barrier to those who try but fail to understand what protection they have if they choose to raise a concern.

9.6 In addition, it provides remedy rather than protection against detriment. It would be extremely difficult, for example, to obtain an injunction to prevent detriment occurring as it would be difficult to prove that detriment was going to happen. There is no evidence that the prospect of an Employment Tribunal (ET) case deters victimisation.

> " *PIDA is reactive, providing a remedy for damage that has already been caused. It does not prevent reprisals."*

9.7 Legal representatives who attended our workshop highlighted that:

- blacklisting would probably be considered detriment under the 1996 Act, but it would be hard to prove
- ETs are not able or equipped to judge whether a disclosure has been managed appropriately. They are not the place for patient safety concerns to be heard, although they can refer an issue for further investigation by a relevant regulator[106].

Dismissal following a protected disclosure

9.8 A worker who believes they have been unfairly dismissed as a result of making a protected disclosure can take their case to an ET. If the ET finds in their favour, they can be awarded compensation and in the case of employees, an order for reinstatement or reengagement may be made.

9.9 Orders for reinstatement and re-engagement are not available to workers who are not employees. Even in the case of employees, an employer cannot be forced to comply with an order to reinstate or reengage a dismissed employee in particular if they believe it is not practical to do so. It has been suggested by some contributors that employers should be forced to take back workers who have been successful in claiming unfair dismissal because of having made a protected disclosure. Others were clear that in practice this would not be a very

104 Whistleblowing in Europe: Legal protections for whistleblowers in the EU, Transparency International
105 *Whistleblowing Framework: Call for Evidence – Government Response*, Department for Business Innovation and Skills, 25 June 2014
106 This process was introduced by the Employment Tribunals (Constitution and Rules of Procedure) (Amendment) Regulations 2010 (SI 2010/131) and is now governed by Regulation 14 of the Employment Tribunals (Constitution and Rules of Procedure) Regulations 2013 (SI 2013/1237)

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effective remedy. For example, where there has been a serious breakdown in the relationship between the worker and the employer, as is often the case if the dispute has gone all the way to an ET, then it is likely that the worker may not want to go back to that specific job. There is also the possibility that a return might reignite tensions in a team.

9.10 Forcing NHS employers to comply with reinstatement orders is not a practical option and I do not consider it appropriate to make a recommendation to that effect. However, it is important to support staff who have obtained such orders to get back to work so that their skills are not lost. The NHS has a moral obligation to support those staff whose performance is sound but who have suffered as a result of speaking up. At 7.3 I set out proposals to support staff to find alternative employment in the NHS.

Discrimination following a protected disclosure

9.11 A number of contributors have expressed concern that they have been blacklisted and we have been given examples of interviews and job offers being retracted at the last minute or references being withheld without apparent reason. Employment checks and references are both acceptable and necessary precautions for employers, particularly in a sector such as the NHS which has a duty to patients, but blacklisting should be unacceptable, indeed, blacklisting for trade union membership is illegal[107]. Amongst the actions taken against such blacklisting the Government has increased the penalty the Information Commissioner's Office can impose for serious breaches of the Data Protection Act 1998 to £500,000.

9.12 There is no legislation expressly outlawing discrimination by persons other than the employer through blacklisting of whistleblowers although it is possible that such activities may be a breach of the Data Protection Act. I consider that the NHS should protect individuals from discrimination in their efforts to find future employment in the service.

9.13 The protections currently offered by employment law to whistleblowers apply across all industry, not just healthcare. They require an employment or quasi-employment relationship between the employer and the worker. In most cases it is unlikely that a potential employer discriminating against a whistleblower while carrying out a recruitment exercise would be caught by these provisions. Thus it appears that a potential employer could be free to refuse to employ a person on the grounds that he or she had made a protected disclosure in the past.

9.14 Discrimination law is at present of no greater assistance. It is unlawful to discriminate in recruitment on the grounds of any of the protected characteristics in the Equality Act 2010, such as race or gender. Being the 'maker' of a public interest disclosure is not one of those characteristics. Currently they relate to something intrinsic to the individual, such as race, gender, disability or sexual orientation. They are all part of what a person is, not what they have done. Any change to cover people who have made a protected disclosure would change the scope of the Act. As with employment law, any extension of statutory protections under the Equality Act would involve a far wider field of activity than just the health service. However the recent legislation banning blacklists of trade union members suggests that it is possible to accord protection to individuals by reference to a status which is not intrinsic to them as a person.

Disclosures to the media

9.15 For a disclosure to be made straight into the public domain, to someone who is not a prescribed person, a higher bar applies (see 2.2.6). I am not proposing any changes to this. Disclosures to the press should be a last resort. There is a strong possibility of misrepresentation if the facts have not yet been investigated. This can be damaging. It can cause considerable distress to the individuals involved, to the organisation as a whole, and can worry the public unnecessarily.

107 Employment Relations Act 1999 (Blacklists) Regulations 2010/493

9.16 The Review did not receive evidence supporting changes to this aspect of whistleblowing. I have therefore focused on improving the mechanism for internal disclosures and disclosures to prescribed persons. If the Principles and Actions proposed in this report are implemented it should not be necessary for anyone to go to the press. Facts about serious concerns will become public in the normal course of events through increased transparency, once the facts have been established.

Conclusion

9.17 Although the existing legislation is weak, I have not recommended a wholesale review of the 1996 Act for two reasons. First, I do not think legislative change can be implemented quickly enough to make a difference to those working in the NHS today. What is needed is a change in the culture and mindset of the NHS so that concerns are welcomed and handled correctly. If this can be achieved, fewer staff will need recourse to the law. Second, this Review is concerned only with the position of disclosures made within one part of the public sector, the NHS. The Act covers all forms of employment whether in the public or private sectors. There may well be different considerations in other fields.

9.18 However I do consider that there are two steps which should be taken:

- extending the list of prescribed persons to ensure NHS workers are protected if they raise a concern with any relevant person/body. There are some surprising omissions from this list. Most notably clinical commissioning groups and NHS England, as commissioners of services, are not included. A wide variety of bodies responsible for training are not included and among scrutiny bodies neither Healthwatch England nor local Healthwatch, unless by implication from the fact the former is a sub-committee of CQC, are included
- extending statutory protection to all students studying for a career in healthcare rather than just student nurses. The Government's response to its 'Whistleblowing Framework Call to Evidence' indicates that it might consider extending the scope to 'other student arrangements similar to student nurses'. In my view there is a compelling case for taking this step.

9.19 There is one more general area where I think consideration needs to be given to strengthening. The evidence I have seen during the course of the Review indicates that individuals are suffering, or are at risk of suffering, serious detriments in seeking re-employment in the health service after making a protected disclosure. I am convinced that this can cause a very serious injustice: they are effectively excluded from the ability to work again in their chosen field. With that in mind, I think that consideration does need to be given to extending discrimination law to protect those who make a protected disclosure from discrimination either in the Employment Rights Act 1996 or the Equality Act 2010 or to finding an alternative means to avoid discrimination on these grounds.

Principle 20: Legal protection

Legal protection should be enhanced

Action 20.1 The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.

Action 20.2 The list of persons prescribed under the Employment Rights Act should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentry and Health Service Ombudsman.

Action 20.3 The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.

10

Conclusion

10.1 It is clear that the concerns which led to the setting up of this Review are justified. While incidents and reports are often handled in accordance with good practice, there is a fear shared by many NHS staff that they will suffer adverse consequences if they raise concerns. Just as worrying is the commonly held belief that nothing effective will be done about concerns if they are raised.

10.2 These fears are understandable in the light of the evidence of the dreadful experiences suffered by far too many staff after raising concerns which were not welcomed by the recipients. Time and again we were told of bullying and other oppressive behaviours, of apparently retaliatory action, and of a focus on finding individuals to blame rather than a rigorously objective and prompt investigation to establish the facts. We looked at the practice of other safety critical sectors and found marked differences in their approach to these issues.

10.3 While poor practice may be inflicted on only a minority of staff this has a disproportionate effect on the governance of the NHS. For every worker who is badly treated, many more will learn from that reported experience that it is better to keep one's head down than it is to speak up. Every time someone decides not to raise an honestly held concern or suspicion about patient safety or improper use of NHS resources, a risk to patients or to the integrity of the service will go unnoticed, unexplored and uncorrected. Just as false comfort can be drawn from statistics suggesting that the majority of patients are well cared for, or that the majority of patient complaints are processed efficiently, it would be quite wrong in the face of the evidence to the Review to be reassured by suggestions that the majority of concerns are handled correctly. Those which are not can cause untold suffering and distress to those involved, not to mention lost opportunities to correct serious risks to the service.

10.4 What is needed is not radical, but a careful and committed application of the principles of a culture of safety and learning. This report has set out 20 Principles which, when implemented together with the measures already being progressed following my previous report into the failings at Mid Staffordshire, will, I believe, go a long way to reduce the number of upsetting cases and deliver the open and honest culture that staff in the NHS need. Each Principle is accompanied by recommended actions.

10.5 Those who raise difficult concerns and those who receive them share a responsibility to conduct themselves reasonably, with empathy and understanding for the difficulties others face, and to recognise that the purpose of all they do must be to protect patients and the public interest. As with all other work in the NHS, success is achieved through teamwork and partnership, not through refusal to accept reasonable challenge and reasoned and fair decisions, or persistence in oppressive and adversarial conduct.

10.6 It will be important that progress is reviewed regularly. Culture change is not a one-off event, but requires constant attention and development. I believe that the widespread introduction of Freedom to Speak Up Guardians, with a national point of reference created through the new post of the Independent National Officer, is a key component in keeping watch over the way concerns are handled, providing support to those who need it, and ensuring the patient safety issue is always addressed. The climate that can be generated by these measures will be one in which injustice to whistleblowers should become very rare indeed, but is redressed when it does occur.

10.7 Finally I recognise that some of those who have contributed so constructively to the Review will feel that their own personal issues have not been addressed. This was perhaps inevitable given my remit, but I have to observe that in some of their cases the contention has endured over such a long time, and the issues have become so complex, that the most rigorous inquiry devoted to each such case would not have been able to resolve matters for those involved. For this reason I doubt that any form of public inquiry of the sort demanded by some would do more than raise expectations only for them to be dashed. I hope, however, that all who have contributed to this Review by

taking the difficult step of sharing with me their sometimes harrowing experiences will receive some consolation from the knowledge that they have informed the lessons identified in the report and made a significant contribution to ensuring that others will avoid suffering the same consequences in future.

10.8 Let us all hope that from now:

- all genuine concerns are responded to by prompt, proportionate and objective investigation of the concern rather than of the person raising it
- all those who raise such issues are valued and thanked for what they have done, rather than bullied and victimised
- genuine issues about an individual's performance or conduct are dealt with fairly and entirely separately from any concerns they may raise
- appropriate support is available to help all with difficulties, whether staff raising concerns, management charged with handling them, or those who are implicated in the matters raised
- all proper concerns result in the necessary learning, shared transparently with all those interested, including the public
- unacceptable breach of the responsibilities identified in this report should lead to appropriate accountability, but above all where there are difficulties the explanation for them must be sought in a blame free environment.

10.9 If these things are achieved the NHS will be a far more congenial place in which to work. Most importantly, it will be a safer place for patients and the public interest in the service will be much better safeguarded.

10.10 There is a a great deal to be done by well-led organisations and regulators to bring to life the Principles in this report. It will be for the Secretary of State for Health to ensure that the momentum is maintained to achieve the required culture change throughout the NHS.

Recommendation 1:

All organisations which provide NHS healthcare and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.[108]

Recommendation 2:

The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.

108 Principles and actions are summarised pn pages 23-28 and the good practice is summarised at Annex A

Annexes

Annex A
Summary of good practice

Good practice – Driving culture change (section 5.2)

- Organisations:
  - explicitly recognise the importance of encouraging staff to speak up freely, and understand the contribution this makes to patient safety, through their actions as well as their words
  - agree a strategy to develop the right culture, which includes tackling factors such as bullying which might inhibit speaking up
  - devote time and attention to bring about this change, through board discussions, visible leadership and monitoring progress. This should include tracking progress on key indicators such as responses to the relevant questions in the NHS staff survey
  - demonstrate that those who speak up are valued and recognise their contribution to improving patient safety
  - provide time and resource so that all staff can engage in reflective practice.
- Boards review progress on driving and maintaining culture change at regular intervals.

Good practice – Making the raising of concerns a normal activity (section 5.3)

- When a staff concern is raised the primary focus is on identifying and resolving any patient safety issues.
- There is an integrated policy and a common procedure that does not distinguish between reporting incidents and raising concerns, and focuses on the safety issue not the possible legal status or other employment issues arising from the concern.
- The policy and procedure:
  - reflects good practice described in this report
  - applies to all staff concerns irrespective of whether the staff member classes it as whistleblowing
  - includes requirements necessary for compliance with any obligation to report issues to patients and the organisation such as professional and statutory duty of candour
  - authorises, and does not prevent or deter staff from raising concerns directly with any prescribed person, as well as any commissioner, but may advise them that the employer welcomes concerns being raised first within the organisation.
- The responsibility for overseeing policy, procedure and practice relating to raising concerns is allocated to the executive board member who has responsibility for safety and quality.
- Investigation of concerns is separate from employment procedures where possible.
- Disciplinary action necessary for any party associated with a concern is not considered or taken until the completion of any investigation and identification of any action required unless there are exceptional circumstances.
- Where a concern is reported to an external body, the organisation reflects, without seeking to blame, on the reasons why this happened.

Good practice – Promoting a no bullying culture (section 5.5)

- Boards ensure that everyone in senior or managerial positions are aware of the importance they attach to eradicating any form of bullying.
- Employers take steps to ensure there is no culture of bullying in the whole of, or individual parts of their organisation. This includes:
  - clearly articulated standards and expectations of staff at all levels
  - developing strategies to work with staff to address bullying where there is evidence that there is a problem
  - regular training for everyone in leadership and managerial positions on how to address and how to prevent bullying including awareness of personal impact and the potential to be perceived by others as oppressive or bullying (see good practice in 7.1)
  - clarity in all relevant policies and procedures that bullying and harassment will not be tolerated, and that conduct of this nature is capable of being regarded as gross misconduct
  - a range of resources and support to address unacceptable behaviour, for example counselling and mediation
  - monitoring all relevant indicators and formal and informal reports of concerns to understand the culture in the organisation
  - fair procedures for dealing promptly with complaints and concerns about bullying.
- Leaders and managers:
  - are clear through their actions as well as their words that bullying and oppressive behaviour is unacceptable and will not be tolerated
  - provide constructive and honest feedback when they see inappropriate behaviour.
- Staff develop self awareness about their own behaviour and its effect on others (see good practice in 7.1).

Good practice – Handling concerns (recording and monitoring) (section 6.2)

- The records of formally raised concerns include:
  - the date on which the concern was made, and when it was acknowledged
  - a summary of the issue and any supporting evidence provided
  - any patient safety issues raised by the concern
  - the gravity and urgency of the issue in the view of both the person raising the concern and the person recording it
  - any actions the person raising the concern(s) considers should be taken to address the issue and by whom
  - the wishes of the person raising the concern regarding disclosure of their identity to others, and confirmation that it has been explained to them that it will not always be possible to protect their identity
  - who will be responsible for taking action on the report.
- Once logged a copy of the record is given:
  - to the person raising the concern
  - the CEO or a designated board member, anonymised if requested, unless that would prejudice the CEO/board member's ability to act on the report. This copy includes what action is to be taken.
- There is a process for onward referral, both internally and externally, and monitoring to avoid cases being 'lost in the system'.
- Feedback is provided, whatever the outcome and whether or not a formal investigation takes place, to all those involved with raising, managing or monitoring the concern, including feedback on progress and the reasons for any change to the agreed timetable.
- The CEO or designated board member regularly reviews all concerns that are brought to their attention; and where they consider it appropriate, the regulator relevant to the case (either system or professional) is informed.
- Anonymous concerns are classed as formal concerns, recorded and followed up in the same way as other formal concerns (see 6.3).
- Appropriate training is mandatory for everyone in an organisation who may receive concerns from staff. It includes the organisation's procedures for recording and handling concerns (see also good practice in 7.1).

Good practice – Handling concerns (the investigation process) (section 6.4)

- The investigation of a staff concern:
  - is done quickly within an agreed timescale that is set out at the start. The person who raised the concern is informed of any changes to the timescale
  - is separate from any disciplinary process involving anyone associated with the concern where possible
  - has a degree of independence proportionate to the gravity or complexity of the issue
  - is conducted by appropriately qualified and trained investigators who are given the time to conduct and write up their investigation as per the agreed timescale. They are not expected to fit this into their normal work schedule. In cases involving death, serious injury or serious levels of dysfunction of system or relations, the investigators are not employed by the responsible organisation
  - seeks to establish the facts by obtaining accounts from all involved and examining relevant records
  - takes into account known good practice or guidelines including clinical guidelines
  - results in feedback of the findings and any recommendations or proposed actions to the person who raised the concern and all those involved taking into account confidentiality issues where necessary
  - confidentiality is not used as an excuse to refrain from providing feedback
  - ensures there is someone who keeps in touch with the person who raised the concern at all times to keep them abreast of progress, and to monitor their well-being.
- The outcome of the investigation is considered at a level of seniority appropriate to the gravity of the issues raised alongside, where relevant, a programme of proposed action.
- The trust has access to a panel of trained investigators, who can respond quickly and with the necessary level of expertise.
- Learning from the investigation is shared across the organisation and beyond where appropriate (see 7.4 on transparency).

Good practice – Suspensions and special leave (section 6.5)

- Suspension of staff involved when concerns are raised is a last resort, where there is no alternative option to protect patient or staff safety, or to maintain the integrity of any investigation or for another compelling reason.
- Alternatives to suspension or special leave are always considered including restricted practice, mediation and support and temporary redeployment to a non-patient facing role or to another site.
- A decision to suspend or give special leave to someone who has raised a concern is only taken by a nominated executive director or directors with the authority of the CEO.
- Any decision to suspend or grant special leave is accompanied by an explicit and recorded consideration of all reasonable, practicable alternatives that have been considered and the reasons they were not appropriate.
- The number of suspensions or special leave resulting from raising concerns and their ongoing justification is regularly reviewed by the board.
- The number of suspensions and special leave resulting from raising concerns is shared with regulators and used as an indicator by both the board and the regulators to consider how concerns are handled in the organisation.
- Staff who are suspended or on special leave following raising a concern are given full support in line with Principle 11 in 7.2.

Good practice – Mediation, reconciliation and alternate dispute resolution (ADR) (section 6.6)

- NHS organisations make full use of mediation, reconciliation and ADR expertise, whether internal or external, at an early stage with the agreement of all parties involved in a dispute or disagreement. It is particularly used:
  - where relationships are poor, to support remedial action to resolve issues before they break down irretrievably
  - where relations have broken down, to try to repair them
  - to build or rebuild trust in a team or a relationship where there has been a difficult issue
  - to support staff involved in a difficult case to prevent or support recovery from stress and mental illness.
- Mediation and similar techniques are undertaken with the agreement of those involved, respecting their confidentiality. Refusal to consent is never considered as a cause in itself for disciplinary action.
- Expert support of this type is also considered prior to, or instead of, disciplinary action where there are concerns about an individual's behaviours or their oppressive management style, in line with the concept of a just culture described in 5.2, although repeated infringements of a type likely to undermine an open and honest culture are not be tolerated.

Good practice – Training staff in raising and handling concerns (section 7.1)

- Every member of the organisation participates in training on raising and handling concerns. It is designed to meet their likely needs with some groups, such as directors, managers and HR, having a more detailed focus on handling than others.
- Training is done in groups, face to face and preferably multidisciplinary, making use of scenarios and role play.
- Training ensures all staff gain an understanding and expectation about the policy, process and support available and what is appropriate and acceptable behaviour when raising and handling concerns. It includes:
  - the process to follow when a concern is raised including the approach to take in terms of investigation and how to prevent a situation escalating
  - how to raise concerns with tact to avoid causing offence or provoking defensive behaviour, including raising concerns in challenging situations e.g:
    - where the person raising the concern has been involved personally and might share some of the responsibility
    - which might affect colleagues or be unwelcome news for a senior manager
    - where it is likely that others may disagree with the person raising the concern
    - where the person raising the concern does not have the full picture.
  - consideration of human factors, how people react under stress and how to challenge hierarchies
  - how to respond appropriately to a concern raised about one's own work or behaviour or that of one's team
  - how to support an individual(s) who raised a concern, and any colleagues involved.
- Training and guidance is available on managing performance issues including if and how they may relate to whistleblowing.

Good practice – Advice and support for staff raising concerns (section 7.2)

People who can support staff with concerns

- A range of people are available to provide advice and support for staff thinking of raising a concern or who have already raised a concern including:
  - a Freedom to Speak Up Guardian(s)
  - a designated non-executive director
  - a designated executive director
  - a nominated manager in each department
  - an independent external organisation, such as a helpline or advisory service.
- The Freedom to Speak Up Guardian:
  - is recognised by all as independent and impartial
  - has direct access to the CEO and the chair of the board
  - has authority to speak to anyone within or outside of the trust
  - is an expert in all aspects of raising and handling concerns
  - has dedicated time to perform this role, and is not expected to take it on in addition to existing duties
  - watches over the process, and 'oils the wheels'
  - offers support and advice to those who want to raise concerns, or to those who handle concerns
  - ensures that any safety issue is addressed and feedback is given to the member of staff who raised it
  - safeguards the interests of the individual and ensures that there are no repercussions for them either immediately or in the longer term
  - takes an objective view where there are other factors that may confuse the issue, such as pre-existing performance issues, to enable these to be pursued separately
  - identifies common themes and ensures that learning is shared
  - raises concerns with outside organisations if appropriate action is not taken by their employer
  - works with Human Resources to develop a culture where speaking up is recognised and valued
  - helps drive culture change from the top of the organisation.
- The designated non-executive director:
  - is an independent voice and champion for those who raise concerns
  - works closely with the Freedom to Speak Up Guardian to act as a conduit through which information is shared with the board
  - provides challenge to the executive team on areas specific to raising concerns and the culture in the organisation.
- The designated executive board lead:
  - oversees and reviews internal raising concerns processes
  - ensures staff feel empowered to raise concerns
  - ensures learning from concerns is shared across the organisation
  - is accountable for the treatment of whistleblowers within the organisation.

(Continued on next page)

Good practice – Advice and support for staff with concerns *(continued)*

Counselling and support

- Staff support and counselling is accessible and available when required to all staff who have raised concerns
- counselling is offered to staff who have been suspended or are on sick/special leave following raising a concern
- organisations keep track of what is happening to staff who have raised a concern and whether they are doing enough to support them.

Team Support

- Open and facilitated team discussions, including reflective practice, are used to create shared ownership of problems and solutions
- team building exercises are used to develop and sustain strong teams where people can speak openly to improve patient safety.

Good practice – Supporting staff back into employment (section 7.3)

- Employers:
  - seek to reinstate staff who have spoken up, offering training, mediation and support where necessary
  - make clear that they welcome job applications from people who have raised concerns at work to improve patient safety
  - consider a history of having raised concerns as a positive characteristic in a potential employee.
- Organisations actively support and participate in the employment support scheme (once set up) for NHS staff and former staff having difficulty finding employment in the NHS as a result of making a protected disclosure and about whom there are no outstanding issues of justifiable and significant concern relating to their performance.

Good practice – Transparency (section 7.4)

Transparency for individuals (see also good practice on investigations 6.4)

- The findings of any investigation are shared with the person who raised the concern and any other staff involved, redacting or editing only what is essential to respect the confidentiality of other individuals involved.

Transparency by organisations

- NHS organisations:
  - collect and analyse information related to staff concerns and triangulate it with information from other sources to help identify trends for further investigation and learning to share
  - publish in Quality Accounts (or equivalent) quantitative and qualitative data about formally reported concerns such as number of concerns raised, action taken and outcome, taking into account patient confidentiality and data protection
  - share information about formally reported concerns or incidents with disputed outcomes with the NRLS, INO (see Principle 15) and relevant regulators and commissioners.

Confidentiality clauses

- Confidentiality clauses are:
  - not automatically included in settlement agreements
  - approved by the CEO to confirm they are consistent with the public interest in transparency when used
  - written in plain English.

Good practice – Personal and organisational accountability (section 7.5)

- Everyone working in an NHS organisation is held accountable for their behaviour or practice. Poor behaviour is inconsistent with the values of a well-led organisation.
- All staff who raise concerns:
  - do so in good faith and in a way that is sensitive to their colleagues and employers
  - have respect for the outcome of an investigation where it has been carried out in line with good practice.
- Discriminating against, or victimising, an NHS worker because they have raised a concern, or turning a blind eye when other officers or employees do so, is regarded as serious misconduct or mismanagement.
- Whistleblowing, employment and Human Resources policies are clear that victimisation, or allowing the victimisation by others, of someone because they have raised a concern will result in disciplinary action.
- Boards:
  - demonstrate by example the constructive and non-judgmental approach they expect staff to adopt
  - have regard to evidence of poor conduct against staff that have raised concerns by anyone they are considering appointing to a senior position.
- Regulators:
  - look for evidence of boards taking their responsibilities related to staff concerns seriously
  - consider the participation in, or permitting of, behaviour or practice that is inconsistent with the values of a well-led organisation by a director or equivalent, in any consideration of whether they are a Fit and Proper Person.

Good practice – Professional regulators (section 7.7)

- Professional regulators:
  - co-ordinate with each other and system regulators to share information and act on it appropriately
  - check whether the registrant about whom a concern has been raised has made one or more protected disclosures in connection with their employer's or healthcare professional's service and consider any relevance of such matters to the issues referred to them
  - carry out screening of referrals and any resulting fitness to practice reviews as quickly as possible
  - treat facts related to a protected disclosure as a relevant matter in their deliberations, satisfying themselves that the individual has been treated fairly and in line with others in the same organisation.

Good practice – The role of organisations involved in education and training (section 8.2)

Training and support from universities and other organisations

- Education and training organisations:
  - cover raising concerns in the course curriculum
  - make available at least one officer responsible for: receiving concerns from clinical students and trainees; offering advice and support; ensuring that the concern is referred to an appropriate person or organisation for investigation; and monitoring the well-being of the student who has raised the concern
  - ensure support (both practical and psychological) is provided throughout any informal or formal raising concerns process
  - ensure that students are given protected time to reflect on their placements, including when they raise concerns, and have a support network in place to help them through difficult situations.

Clinical placements

- Organisations offering clinical placements make available to clinical students and trainees the same procedures for raising concerns, obtaining advice and support and means of investigating concerns as for their regular staff.
- Providers of a clinical placement inform the responsible educational or training organisation if a clinical student or trainee makes a public interest disclosure or raises a comparable concern, unless the student has specifically asked that this is not done.

Assessments

- Educational or training organisations review any adverse assessment of the competence or fitness of a clinical student or trainee who has made a public interest disclosure or has raised a comparable concern to ensure that it has not caused or contributed to a disadvantage or detriment in an assessment.

Education and training organisations and regulators

- Education and training organisations and regulators:
  - work closely when assessing the suitability of placements for students ensuring that they are good quality placements that will add value to the clinical student or trainee working in the NHS
  - consider how credit for raising concerns that have contributed to patient safety can be given in students and trainees assessments.

Regulators

- Regulators do not validate any course/placement whic repeatedly receives poor feedback or where concerns have continually been ignored.

Annex B
Actions by organisation

ACTION	SUMMARY	DH	NHS ENGLAND	SYSTEM REG	PRO REG	HEE	ALL ORGS incl. PROVIDERS
1.1	Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.						✓
1.2	System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.			✓			
2.1	Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.						✓
2.2	NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.		✓	✓			
3.1	Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.						✓
3.2	Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well led.			✓			
3.3	Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.			✓			✓
4.1	Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.						✓
5.1	Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.						✓
6.1	All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.						✓
7.1	Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.						✓
7.2	All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.						✓
8.1	All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.						✓
9.1	All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: • address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern • repair trust and build constructive relationships.						✓
10.1	Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.		✓			✓	✓

11.1	The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) a person (a ‘Freedom to Speak Up Guardian’) appointed by the organisation’s chief executive to act in a genuinely independent capacity b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation’s culture to the Board c) at least one nominated executive director to receive and handle concerns d) at least one nominated manager in each department to receive reports of concerns e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.						✓
11.2	All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.						✓
11.3	NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.		✓	✓			
12.1	NHS England, NHS TDA and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as result of having made protected disclosures.		✓	✓			
12.2	All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.						✓
13.1	All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.						✓
13.2	All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.		✓	✓			✓
13.3	a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest. b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case. d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.			✓			✓
14.1	Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.						✓
14.2	Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.			✓			✓
14.3	All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.			✓			✓

15.1	CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post of an Independent National Officer (INO) might jointly be created and resourced and submit proposals to the Secretary of State as to how it might carry out these functions in respect of existing and future concerns.		✓	✓			
16.1	CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.	✓		✓			
16.2	Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.				✓		
17.1	CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.			✓			
18.1	Professional regulators and Royal Colleges, in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the Principles and good practice in this report.				✓	✓	
18.2	All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns.					✓	
19.1	NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.		✓				
19.2	NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.		✓				✓
19.3	In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.			✓			
20.1	The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.	✓					
20.2	The list of persons prescribed under the Employment Rights Act should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentry and Health Services Ombudsman.	✓					
20.3	The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.	✓					

Annex C
Organisations that contributed to the Review

Academy of Medical Royal Colleges
Action against Medical Accidents
Association of Surgeons in Training
British Medical Association
British Psychological Society
Campaign Against Unnecessary Suspensions and Exclusions (UK)
Capsticks Solicitors LLP
Care Quality Commission
Centre for Effective Dispute Resolution
Chartered Society of Physiotherapy
DAC Beachcroft LLP
Department for Business, Innovation and Skills
Department of Health
Doctors Support Group
Financial Conduct Authority
Foundation Trust Network
General Dental Council
General Medical Council
General Pharmaceutical Council
Health and Care Professions Council
Health Education England
Human Fertilisation & Embryology Authority
Medical Protection Society
Medicines & Healthcare products Regulatory Agency
Monitor
National Audit Office
NATS
NHS Confederation
NHS Employers
NHS England
NHS Leadership Academy
NHS Litigation Authority
NHS Trust Development Agency
Nursing and Midwifery Council
Parkinsons UK
Patients Association
Patients First
Professional Standards Authority
Public Concern at Work
Royal College of Anaesthetists
Royal College of General Practice
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics & Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatry
Royal College of Radiologists
Royal College of Surgeons of England
Royal College of Surgeons, Edinburgh
Scottish Workforce & Staff Governance Committee
Society & College of Radiographers
South West Whistleblowers Health Action Group
Thames Water
The Medical Defence Union
The Royal Society of Medicine – Student Members Group
Tullow Oil
Unison
Unity Portal
University of Nottingham
Virgin Atlantic
Whistleblowers UK
Whistleblowing Helpline
A number of NHS trusts and foundations trusts also contributed to the Review

Annex Di
Survey results – trust and primary care staff

The full results of the staff surveys are available at www.freedomtospeakup.org.uk. The following is a summary of results used in this report. It should be noted that not all staff answered every question on the surveys – some were not relevant to them. The baseline number for each question therefore varies and has been quoted to avoid being misleading or causing confusion.

Respondents

- In total, 19,764 staff responded to our surveys which included 15,120 staff in NHS trusts and 4644 staff working in primary care (general practice and community pharmacies).

Experiences of whistleblowing

- Around a third of the staff working in trusts (35.4% n = 5020) and just under a quarter of the staff from primary care (21.6% n = 945) reported having raised a concern about 'suspected wrongdoing' in the NHS.

Culture

- Around two thirds of respondents to the trust staff survey (64.6% n = 9174 of 14194) said that they had not raised a concern about wrongdoing in the NHS. Of these, 17.9% (1581 of 8851) indicated that this was due to a lack of trust in the system and 14.9% (1315 of 8851) indicated that fear of being victimised was a deterrent.
- Over three quarters of respondents to the primary care survey (78.4% n = 3437 of 4382) said that they had not raised a concern about wrongdoing in the NHS. Of these, 7.5% (251 of 3341) indicated that this was due to a lack of trust in the system and 10.4% (347 of 3341) indicated that fear of being victimised was a deterrent.

Raising Concerns

Policies and Procedures

- Around a quarter of staff were not aware of their organisations whistleblowing /confidential reporting procedures (23.8% (n = 3264 of 13710) of staff in trusts and 25.7% (n = 1098 of 4271) of staff in primary care). A very small number of staff also indicated that their organisations did not have a policy at all.

Seeking advice about concerns/raising concerns

- Just over half of trust and primary care staff responding to our survey who said that they had raised a concern noted they had not obtained advice first (55.5% n = 2493 of 4490 and 55.3% n = 445 of 805 respectively).
- External help lines did not appear to be a key source of advice for either trust or primary care staff responding to the survey – 4.0% of trust staff (n = 79 from 1989 staff) and 8.9% of primary care staff (n = 32 of 358 staff) reported using this resource.
- Where staff had sought advice, a work colleague was the most common source (70.5% of trust staff (n =1402 of 1989 staff) and 61.7% of primary care staff (n = 221 of 358 staff). Trade unions and professional bodies were the next most favoured sources for staff in trusts, whereas in primary care it was a professional body or friends and family.

Where staff raise concerns first

- Around half of staff responding raised concerns with their line manager, usually informally, in the first instance (52.3% of trust staff (n = 2251 of 4303) and 49.4% of primary care staff (n = 336 of 680) raised concerns informally with their line managers first.

Raising concerns anonymously

- In our survey, staff were asked if a range of measures would make it likely or unlikely that they would raise concerns about suspected wrongdoing in the future. The ability to report anonymously was the second most supported option by trust staff (68.9% n = 2881 of 4179) and the most supported option by primary care staff (68.2% n = 496 of 727).

Raising concerns externally

- From our trust staff survey it appears that the majority of staff who raised a concern internally did not then take their concern outside of their organisation (89.1% n = 2235 of 2508). This proportion is lower in primary care where 58.0% of staff (n = 233 of 402) reported that they did not take their concern outside of the organisation.
- Of the very small number of staff reporting raising a concern outside their organisation, a trade union (38.0% n = 104 of 274 staff) or a professional body (35.0% n = 96 of 274 staff) were the most commonly reported routes for staff in trusts. For staff in primary care a professional body (53.7% n = 87 of 162 staff) or a health service regulator (32.1% n = 52 of 162 staff) were the most common routes. In the interviews, the CQC was the most frequently mentioned external channel referred to when the decision to go outside an organisation was made.
- In our trust staff survey only 1.8% of staff (n = 5 of 274 staff) reported going to the media and in primary care only 1.9% of staff (n = 3 of 162 staff) reported using this route.

Handling Concerns

- Our staff survey indicated that a substantial proportion of staff did not use the employer's procedure to raise a concern (63.5% of trust staff (n = 2374 of 3741) and 52.5% of primary care staff (n = 325 of 619)). The reason for this was not clear.

Feedback after raising concerns

- Of staff who told us their concerns were investigated, around three quarters in both trusts and in primary care stated that they were told the outcome of the investigation. However, this left around a quarter that were not (26.6% of trust staff (n = 493 of 1855) and 20.6% of primary care staff (n = 77 of 374)).

Satisfaction with investigation of concerns

- A sizeable proportion of staff responding to our trust and primary care surveys reported that they were not satisfied with the response to their concern (60.5% of trust staff (n = 2589 of 4278) and 46.9% of primary care staff (n = 317 of 676)). The reason for this dissatisfaction was unclear. However, on the positive side, around three quarters of staff who said they had raised a concern said that they were likely or highly likely to raise a concern again if they suspected serious wrongdoing within their organisation (72.0% of trust staff (n = 3074 of 4274) and 77.6% of primary care staff (n = 581 of 749)).

Detriment after raising concerns

- Although the numbers are small, it would appear from our trust staff survey that staff are more likely to be victimised or ignored by management after raising a concern than they are to be praised. Co-workers appear more likely to praise staff for raising a concern than management.
  - 19.7% of staff in the trust survey reported being ignored by management (n = 847 of 4292 staff)
  - 17.3% reported being victimised by management (n = 743)
  - 8.8% reported being praised by management (n = 378)

In contrast:

- 9.1% reported being ignored by co-workers (n = 389)
- 8.2% reported being victimised by co-workers (n = 350)
- 15.6% reported being praised by co-workers (n = 668)

The primary care staff survey showed similar results although the numbers are very small.

- a sizeable minority of staff reported that they felt unsafe or very unsafe after raising a concern (30.5% of trust staff (n = 1304 of 4282) and 24.9% of primary care staff (n = 187 of 751)).
- a substantial minority of respondents said that they would either be 'unlikely' or 'highly unlikely' to raise a concern again in future if they suspected serious wrongdoing in their workplace (19.1% of trust staff (n=817 of 4,274) and 15.8% of primary care staff (n=118 of 749).

Annex Dii
Survey results – BME staff

The full results of the BME analysis of the staff surveys are available at www.freedomtospeakup.org.uk. The following is a summary of results used in this report. It should be noted that not all staff answered every question on the surveys – some were not relevant to them. The baseline number for each question therefore varies and has been quoted to avoid being misleading or cause confusion.

BME staff in trusts

- 9.8% (n = 1475 of 15006) of trust staff who responded to our survey were from a BME background. This excludes those reporting themselves as white non-British. The largest BME group reported being from an Asian or Asian British background, making up 4.9% of the total respondents (n = 738 of 15006) and about half of the BME respondents.
- A quarter of BME staff responding to the trust survey (25.7% n = 359 of 1395) were from a nursing or midwifery background. The next highest group was allied health professionals or those from a scientific and technical background (21.6% n = 301) followed by wider healthcare team (20.4% n = 285) and medical and dental (18.9% n = 264).We did not collect data related to grade.

Reasons for not raising concerns

- Of the 859 BME staff in trusts who reported that they had never raised a concern about suspected wrong doing in the health service:
  - 24.1% (n = 207 of 859) reported that this was due to fear of victimisation
  - 19.0% (n = 163) reported that they did not trust the system.

Both these proportions were higher for staff from a BME than a white background where 13.8% (n = 1097 of 7941) and 17.7% (n = 1402) reported these factors respectively.

- Of the BME staff in trusts who reported having raised a concern about suspected wrongdoing about half (49.2% n = 189 of 384) first raised their concerns with their line manager informally, similar to the proportion of staff from a white background (52.6% n = 2052 of 3903). However:
  - they were more likely to have reported concerns about harassment/bullying 49.3% (n = 201 of 408) or discrimination (32.4% n= 132 of 408) than staff from a white background (42.4% n = 1733 of 4085 and 12.8% n = 521 respectively)
  - they appeared to be less satisfied with the response to their concern (not necessarily from a line manager) than staff from a white background. 40.7% (n = 1581 of 3880) of staff from a white background were satisfied compared to only 27.0% (103 of 382) of BME staff.

- After raising a concern BME staff were:
  - more likely to be victimised by management than staff from a white background. 21.0% (n=112 of 533) of staff from a BME background stated that they were victimised by management after raising their concern compared to 12.5% (n=626 of 5007) of staff from a white background
  - more likely to be ignored by management than staff from a white background. 19.3% (n=103 of 533) of staff from a BME background stated that they were ignored by management after raising their concern compared to 14.7% (n=737 of 5007) of staff from a white background

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  - slightly more likely to be victimised by co-workers than staff from a white background. 8.6% (n=46 of 533) of staff from a BME background stated that they were victimised by co-workers after raising their concern, compared to 6.0% (n=300 of 5007) of staff from a white background
  - less likely to be praised by management than staff from a white background. 3.0% (n=16 of 533) of staff from a BME background stated that they were praised by management after raising their concern compared to 7.2% (n=362 of 5007) of staff from a white background.

- After supporting a colleague who had raised a concern, BME staff were:
  - more likely to report having suffered detriment (19.9% n =254 of 1274) than staff from a white background (14.8% n =1801 of 12169)
  - more likely to report having been victimised by management (62.5% n=157 of 251) compared staff from a white background (55.3% n=984 of 1778)
  - more likely to report having been victimised by co-workers (33.5% n=84 of 251) compared to staff from a white background (24.6% n=437 of 1778).

- BME staff reported being less likely to report a concern again if they suspected wrongdoing than staff from a white background:
  - 59% (n=225 of 381) of BME staff stated that they were either 'highly likely' or 'likely' to a raise such a concern again compared to 73.4% (n=2843 of 3877) of staff from a white background
  - 27.3% (n=104 of 381) of BME staff stated that they were either 'unlikely' or 'highly unlikely' to raise such a concern again compared to 18.2% (n=706 of 3877) of staff from a white background.

BME staff in primary care

- 23.9% (n = 1097 of 4594) of primary care staff who responded were from a BME background. This excludes those reporting themselves as white non-British. As for the trust survey, the largest BME group was from an Asian or Asian British background, making up 16.1% (n= 741 of 4594) of the total respondents and about two thirds of the BME respondents.
- The vast majority of respondents (94.7% n = 1011 of 1068) were from a pharmacy background. The remaining 5.3% worked in general practice, including 3% of respondents who were GPs and 1.1% of respondents who were practice managers.

Differences between staff in trusts and primary care

- The messages from our primary care survey are broadly in line with those from our trust survey with the exception that:
  - BME staff in primary care were broadly as satisfied as staff from a white background with the response to their concern whereas in trusts, staff from a BME background were considerably less satisfied with the response to their concern than staff from a white background (50.4% (n = 71 of 141) of BME staff and to 54.1% (n = 288 of 532) of staff from a white background in primary care were satisfied compared to 73.0% (n = 279 of 382) of BME staff and 59.3% (n = 2299 of 3880) of staff from a white background in trusts
  - staff in primary care, both BME and from a white background were generally more satisfied with the response to their concern than corresponding staff in trusts (50.4% (n=71 of 141) of BME staff and 54.1% (n=288 of 532) of staff from a white background working in primary care were satisfied with the response to their concern, compared to 27.0% (n = 103 of 382) of BME staff and 40.7% (n = 1581 of 3880) of staff from a white background).

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Annex Diii
Survey results – system and professional regulators

The full results of the regulator survey are available at www.freedomtospeakup.org.uk. The following is a summary of results used in this report. The baseline number for each question varies and has been quoted to avoid being misleading or causing confusion.

Raising Concerns

- 4 of 11 had a telephone hotline dedicated to the reporting of concerns.
- 11 of 13 allowed concerns to be reported anonymously.
- 10 of 13 sought to ensure the confidentiality of a named person raising a concern although 8 of 10 noted that this might not be possible in all circumstances.

Handling Concerns

- 9 of 12 advised that people should initially report concerns about suspected wrongdoing to their employer.
- 7 of 12 provided written guidance to employers about management's responsibility to support whistleblowers.
- 11 of 13 kept the person reporting the concern informed of progress of any investigation.
- 6 of 7 published the number of concerns raised with them and the number of investigations conducted as a result of concerns being raised
- 5 of 7 published the outcome of investigations.

Annex E
Glossary of terms and abbreviations[109]

Terms used in the Review report

- **Agenda for Change** – the national pay policy for all non-medical staff directly employed by the NHS, except some very senior managers.
- **Alternative dispute resolution (ADR)** – a collective term for one of a number of means of dispute resolution (such as mediation, conciliation, referral for informal determination or arbitration) short of formal litigation or other such proceedings.
- **Blacklisting** – the process by which a document containing details of individuals is compiled for the purpose of discrimination in relation to either recruitment or the treatment of workers.
- **Compromise agreement** – see settlement agreement.
- **Confidentiality clause** – a term in a settlement agreement which prevents one or both parties to the agreement from disclosing any of the information expressly defined as confidential in the agreement. This is sometimes referred to as a gagging clause.
- **Contributor** – an individual who made a written submission to the Review or who attended a meeting, seminar or workshop arranged by the Review.
- **Duty of Candour (DoC)** – introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this relates to the statutory duty of candour placed on all health service bodies, and, from 1 April 2015, all other care providers registered with the CQC. This duty requires providers to be open and honest with patients, or their representatives, when unintended or unexpected harm has occurred during their treatment[110].
- **Detriment** – harm or damage suffered, for example bullying or the loss of employment, as a result of having raised a concern.
- **Fit and Proper Person Test (FPPT)** – introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this imposes a new requirement on NHS trusts, foundation trusts and Special Health Authorities to ensure that their board-level directors (or equivalents) are fit and proper persons for their role, for example that they are of good character, appropriately qualified and competent to perform their duties. Additionally, a fit and proper person must not have been involved or complicit in any serious misconduct, management or failure of care elsewhere in a regulated health or care service[111].
- **Gagging clause** – see confidentiality clause.
- **Local Risk Management Systems (LRMS)** – systems which collect data related to patient harm and near misses within NHS organisations.
- **Maintaining High Professional Standards (MHPS)** – framework for handling concerns about the clinical performance, conduct and health of doctors and dentists.
- **Mediation** – A voluntary and typically confidential form of alternative dispute resolution involving the use of a neutral third party to resolve disputes or conflicts or to address interpersonal issues.
- **NHS Constitution** – the document which establishes the values and principles that guide the NHS in England. It sets out the rights and responsibilities of those who work in and use the NHS.
- **NHS organisations** – all organisations in England that provide NHS care or care paid for by the NHS, including private companies providing services on behalf of the NHS.
- **NHS employee** – Any person who is directly employed by an NHS Organisation.

109 There are some terms I have used in this report that are open to interpretation. This glossary explains the context I am using for such terms alongside those that may be less well understood by the general reader. The meaning assigned to terms and abbreviations is that to be understood unless otherwise indicated by the context
110 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936
111 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936

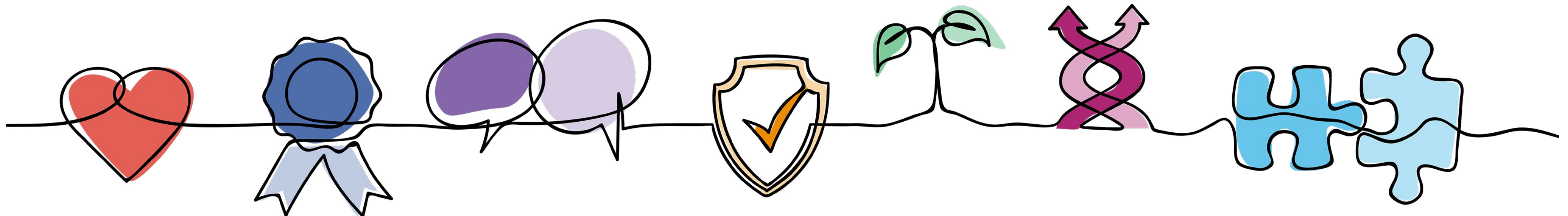
- **NHS staff/staff** – See NHS worker
- **NHS Worker** – for the purposes of this report, this term includes any person who is:
  - employed by an NHS organisation
  - being trained by and NHS organisation (including students on placements)
  - employed by a contractor providing services for the NHS, such as contract domestic workers
  - working as a locum or other temporary agency staff.
- **Primary Care Trusts (PCT)** – part of the NHS in England responsible for commissioning primary, community and secondary health services from providers and providing some community health services directly. They were abolished on 31 March 2013 as part of the Health and Social Care Act 2012.
- **Professional regulators** – the regulators of registered healthcare professionals in the UK and Northern Ireland. This includes the General Medical Council (GMC), Nursing and Midwifery Council (NMC), General Chiropractic Council, General Dental Council (GDC), General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, and the Professional Standards Authority.
- **Protected disclosure** – a disclosure qualifying for protection, as defined by S43B of the Employment Rights Act 1996 (see paragraph 2.2.4 of the report).
- **Public interest disclosure** – a public interest disclosure is any disclosure made by a worker about any wrongdoing in their workplace (such as an issue of patient safety), as defined in Part IVA of the Employment Rights Act 1996.
- **Quality Accounts** – a report published annually about the quality of services provided by a particular NHS organisation.
- **Raising a concern** – reporting a concern, usually relating to patient safety or the integrity of the system, including concerns about bullying or dysfunctional working relationships.
- **Reconciliation** – the process by which two or more divergent viewpoints are brought together so that they are compatible with one another.
- **Reflective practice** – any one of a number of initiatives in which those who work in healthcare, usually in multidisciplinary groups, consider an aspect of their work or practice.
- **Remedy** – the action (such as reinstatement of job role) or compensation ordered by an Employment Tribunal to a successful claimant.
- **the Review** – the Freedom to Speak Up Review
- **Royal Colleges** – the medical Royal Colleges across the UK whose primary interests are post graduate education and training and standards of clinical practice. They also have general interest in healthcare policy.
- **Settlement agreement** – a legally binding contractual agreement between employer and employee which can be used to end an employment relationship or resolve an onging workplace dispute on agreed terms.
- **Speaking up** – see Raising a concern.
- **Students and trainees** – all students and trainees working towards a career in healthcare including medical students and trainee doctors.
- **System regulators** – the financial and quality regulators of NHS services (Monitor, the Care Quality Commission, the NHS Trust Development Agency).
- **Training bodies** – organisations that train or oversee the training of people working in, or who will work in NHS organisations, including universities and colleges.
- **Training bodies** – organisations that train or oversee the training of people working in the NHS or who will working in the NHS.
- **Well-led** – the element of the CQC's inspection process that aims to assess the leadership, culture and values of an organisation.
- **Whistleblower** – a person who raises concerns in the public interest. For the purpose of concerns relating to the NHS, and in particular patient safety concerns, the term 'whistleblower' is used in this report to apply to those who speak up when they see something wrong usually relating to patient safety but also to the integrity of the system.

Abbreviations and acronyms used in report

ACAS	The Advisory, Conciliation and Arbitration Service (UK)
BMA	The British Medical Association
CQC	Care Quality Commission
CCG	NHS Clinical Commissioning Group
CEO	Chief Executive Officer
DH	Department of Health
ET	Employment Tribunal
GMC	General Medical Council
GP	A General medical practitioner
HEE	Health Education England
HR	Human resources departments or officers
NAO	National Audit Office
NCAS	National Clinical Assessment Service
NED	Non-executive director
NMC	The Nursing and Midwifery Council
NHS TDA	The NHS Trust Development Agency
NRLS	National Reporting and Learning System
PCaW	Public Concern at Work
PHSO	Parliamentary and Health Services Ombudsman
PIDA	The Public Interest Disclosure Act (the name used commonly to refer to the whistleblowing legislative provisions in the Employment Rights Act 1996)
RCN	Royal College of Nursing
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
The 1996 Act	The Employment Rights Act 1996, as amended (ERA) (The 1996 Act). The legislation in which the rights of workers to make a protected disclosure and find recourse for detriment is contained
The 1998 Act	The Public Interest Disclosure Act 1998 or 'PIDA' is the legislation which inserted whistleblowing legislative provisions into the 1996 Act.
The 2013 Act	The Enterprise and Regulatory Reform Act 2013. This introduced significant changes to Part IVA and Part V and other whistleblowing legislative provisions in the 1996 Act

Freedom to Speak Up policy for the NHS

Version 2, June 2022.



Publication approval reference: PAR1245_i

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Speak up – we will listen

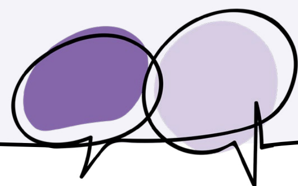
We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos



This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) [list of relevant links to local policy/process documents]. That's fine. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

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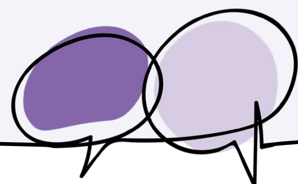
We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.



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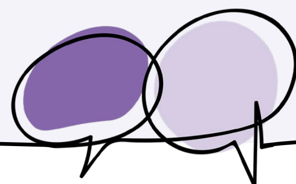
Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and depending on the size of the organisation you work in (some of the options set out below will only be available in larger organisations).

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) [include local contact details].
- Our HR team [include contact details].
- Our Freedom to Speak Up Guardian [insert name(s) and contacts details], who can support you to speak up if you feel unable to do so by other routes. [Include explanation of the status of the guardian if they sit outside your organisation and/or are shared with other organisations.] The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Local counter fraud team (where concerns relate to fraud) [include local contact details].
- Our senior lead responsible for Freedom to Speak Up [insert name and contact details] - they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up [insert name and contact details – this role is specific to organisations with boards and can provides more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed].



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Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

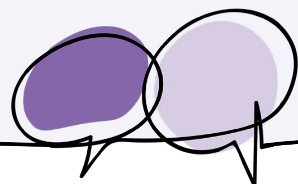
NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.



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How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

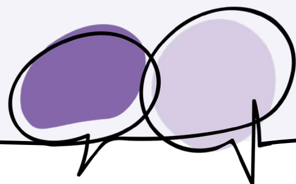
Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.



Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

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What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix A.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

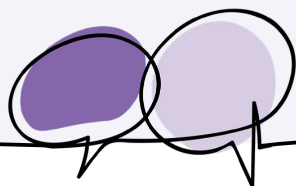
Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.



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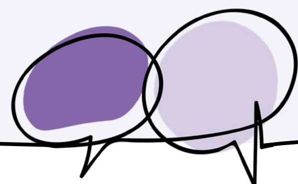
Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).



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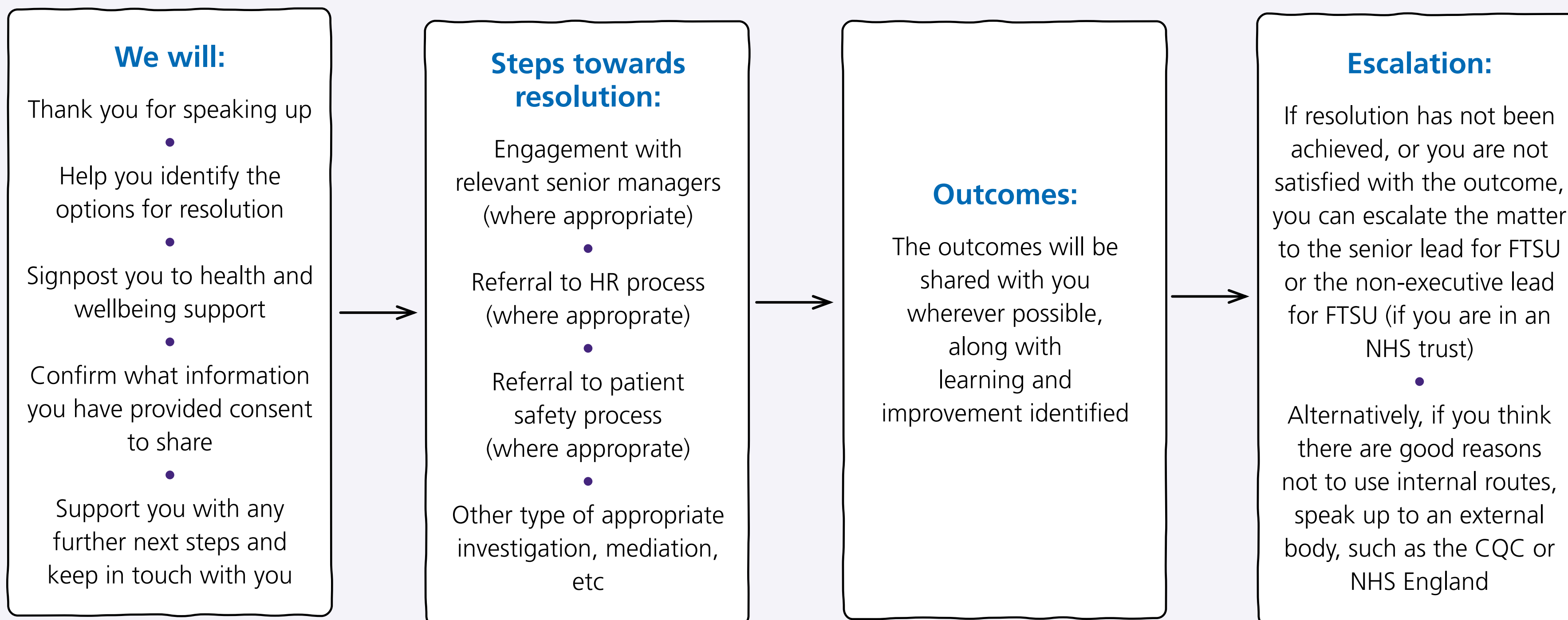
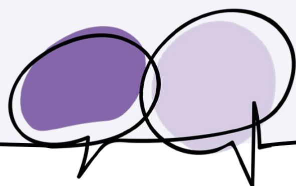
Appendix A:
What will happen when I speak up?





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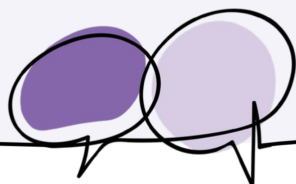
Appendix B:
Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.



Belfast Health and
Social Care Trust

Trust Policy Committee

TITLE	**Whistleblowing Policy**

Summary	The Policy sets out the process to be followed in the case of disclosure by Employees of malpractice, including illegal acts or omissions at work
Purpose	To encourage a climate of honesty and openness in which it is safe and acceptable for any members of staff to raise concerns internally, and at the earliest possible time. When genuine concerns have been raised in good faith, staff in accordance with this Procedure will be protected against victimisation or any other detrimental treatment related to their act of disclosure.
Operational date	September 2008
Review date	September 2009
Version Number	Final Draft
Supersedes Previous	NA
Director(s) Responsible	Medical Director
Lead Author(s)	Paul Ryan : Head of Office of Chief Executive Joan Peden : Co-Director for Workforce Governance, Employment Equality and Improving Working Lives
Additional Author(s)	Policy Committee
Department / Service Group	Medical Directors Office Governance
Contact details	Paul Ryan Tel : 028 9096 0016 / paul.ryan@belfasttrust.hscni.net Joan Peden Tel : 028 9063 6110 / joan.peden@belfasttrust.hscni.net

POLICY STATEMENT ON WHISTLE BLOWING AT WORK

The Belfast Health & Social Care Trust is committed to achieving the highest possible standards of service and the highest ethical standards in all its practices. To achieve these ends it promotes openness and encourages staff to speak freely and contribute their views on health and social care activities especially those relating to the delivery of care to patients and clients.

In introducing the Whistle Blowing Policy the Trust strives to encourage a climate of honesty and openness in which it is safe and acceptable for any member of staff to raise concerns internally and at the earliest possible time.

Staff are recommended to use internal procedures for reporting genuine concerns regarding malpractice or illegal acts at work by Trust employees. When genuine concerns have been raised in good faith, staff in accordance with this procedure will be protected against victimisation or any other detrimental treatment related to their act of disclosure.

The Trust Board and Chief Executive are fully committed to this Policy and its implementation.

______________________	______________________
Chairman	Chief Executive
______________________	______________________
Date	Date

1. INTRODUCTION

1.1 The Term "whistleblowing" refers to the disclosure by employees, of wrong doing including fraud, financial irregularity, serious maladministration arising out of improper conduct, unethical activities which may be of a criminal nature or acts or omissions which create a risk to the health and safety within the Organisation to which we belong.

1.2 This policy has been developed in recognition of the fact that individual members of staff in the Belfast Health & Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have.

1.3 The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

1.4 The policy takes account of the Public Interest Disclosure (NI) Order 1998 and Circular HSS (Gen) 1/2000. It does not affect existing complaint procedures and it complements professional and ethical rules, guidelines and codes of conduct relating to complaints and freedom of speech.

2. AIMS & OBJECTIVES

2.1.1 The aim of the Policy is to promote a culture of openness, transparency and dialogue which at the same time: -

- reassures staff that they will not be penalised for raising a genuine concern and gives them a process to follow
- upholds patient confidentiality
- does not unreasonably undermine confidence in the service
- meet the obligations of staff to their employer
- Contribute towards improving services provided by the Trust

2.2 The Objectives of the Procedure: -

- Encourage staff to raise matters of concern internally and advise on how the matter should be raised

- Provide an effective and confidential process by which staff can raise genuine concerns so that patients, clients and the public can be safeguarded
- Ensure staff have the opportunity of free speech without fear of victimisation, reprisal or reproach from the Trust Board or its Management
- Assist in the prevention of fraud and mismanagement
- Demonstrate to staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards

The Trust recognises that employees may wish to contact outside bodies, however, the Trust would encourage staff to use the internal process set out in this policy.

3. SCOPE OF THE POLICY

3.1 The Trust recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Harassment & Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way. The Whistleblowing Policy provides a procedure for staff to raise genuine concerns internally on malpractice relating to criminal activity, failure to comply with a legal duty, miscarriages of justice, danger to health and safety or the environment and the concealment of any of these issues in the workplace.

Examples may be: -

- Malpractice or ill treatment of a patient by a member of staff
- Repeated ill treatment of a patient despite a complaint being made
- Where a criminal offence has been committed, is being committed or is likely to be committed
- Suspected fraud
- Disregard for legislation, particularly in relation to Health and Safety at Work
- The environment has been, or is likely to be, damaged
- A miscarriage of justice has occurred, is occurring, or is likely to occur
- Breach of Standing Financial Instructions
- Showing undue favour over a contractual matter or to a job applicant
- Research misconduct

- Information on any of the above has been, is being, or is likely to be concealed

This list is not intended to be exhaustive or restrictive.

3.3 The policy is not intended for personal issues that should be properly raised under existing Grievance Procedure arrangements.

3.4 This policy compliments professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allows questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. PUBLIC INTEREST DISCLOSURE (NI) ORDER 1998

4.1 This policy and procedure has been introduced in compliance with the provisions of the above order which took effect 31 October 1999. The order gives significant statutory protection to employees who disclose information reasonably and responsibly in the public interest. It sets out the circumstances in which disclosures of information are protected. To be protected under the law an employee must act in good faith with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may also be made to certain prescribed persons or bodies external to the Trust listed in the order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

4.2 The Trust Medical Director is the designated Executive responsible for ensuring the appropriate protections are applied. The Head of Office is the Designated Person to be the initial point of contact for complaints under this Procedure.

4.3 Staff are expected to treat many matters confidentially however the Trust does not operate any policy or clause in employee contracts which prevent staff from raising issues of concern protected by the Order. Where staff raise genuine, but unfounded concerns they will not face disciplinary action. Disciplinary action would only be considered if the disclosure was made in bad faith e.g. falsely or maliciously or in pursuit of a personal grudge.

4.4 If a member of staff is penalised or victimised for making a protected disclosure he or she can bring their case to an industrial tribunal. However the Trust has agreed that it expects staff to raise concerns about malpractices and that deterring someone from using the procedure or victimising someone who does will be viewed as a disciplinary matter.

5. RESPONSIBILITIES

5.1 The Trust

- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honest and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.

5.2 Managers

- To take any concerns reported to them seriously and consider them fully and fairly
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the Trust where appropriate
- To invoke the formal procedure and ensure the designated officer is informed, if the issue is appropriate

5.3 All Members of Staff

- To recognise that it is their duty to draw to the Trust's attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain their duty of confidentiality to patients and the Trust and consequently, where any disclosure of confidential information is to be justified, the employee should first, where appropriate, seek specialist advice from for example a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical Council.

6. PROCEDURE

6.1 Informal Procedure

6.1.2 If an employee has a genuine concern about what they believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with their Line Manager, or if there are specific reasons for not doing so the matter should be reported to the appropriate Senior Manager/Director.

6.1.3 Employees are entitled to representation from a Trade union/fellow worker or companion in assisting them raise such a matter of concern.

6.1.4 If the concern can be resolved at a local level, then the Line Manager will take the appropriate action and the staff member will be notified of the action taken within five working days of having raised the concern. If additional time is needed the timescale will be reviewed and communicated.

Where action is not considered practicable or appropriate the staff member should be provided with an explanation of the reasons within the timescale or revised timescale.

6.1.5 If informal action does not allay concerns, then the employee should invoke the formal procedure outlined below.

6.1.6 Where appropriate the Manager may decide to refer the issue to the Trust Designated Person to be dealt with under the formal procedure below).

6.2 Formal Procedure

In the event that the matter raised cannot be dealt with informally or under any of the Trusts other Procedures for dealing with conduct and behaviour at work, as specified at paragraph 3, then the following Procedure should be invoked:-

6.2.1 The Trust has appointed a Designated Person to be the initial point of contact for complainants under this Procedure. The Designated Person will have direct access to the Chair/Chief Executive. In some situations a member of staff may have initially discussed the matter with their Line Manager. It is important that the matter is immediately brought to the attention of the Designated Person.

Designated Person:	Mr Paul Ryan
Title:	Head of Office
Location:	Chief Executive's Office
Telephone Number:	028 90 960016

6.2.2 The Designated Person will arrange an initial interview with the complainant, which will be strictly confidential and will ascertain the area of concern. The complainant may be represented by a Trade Union representative or fellow worker/companion. The Designated Person will seek to reassure the complainant about protection from possible reprisals or victimisation and give them a copy of this Policy. The Designated Person will write a summary report of the interview which will be agreed by both parties, and will ask the complainant to make a written statement.

6.2.3 The Designated Person will report to the Chief Executive.
However, if the complaint is about the Chief Executive the Designated Person should report to the Chair. In the event the complaint is about the Chair of the Trust it should be referred to the Permanent Secretary, Department of Health, Social Services & Public Safety. If the complaint concerns the improper use of public funds then the Designated Person should have direct access to the Chair of the Trust's Audit Committee.

6.2.4 The Chief Executive, or the Chair or Designate Person as appropriate, will be responsible for the commission of the investigation. This investigation will be carried out by an independent individual(s) (Investigating Officer(s))/Panel. The Investigating Officer(s)/Panel will conduct a full investigation which will be carried out under the terms of strict confidentiality. The Designated Person will be kept informed of progress.

6.2.5 In serious cases, for example allegations of ill treatment of patients, fraud, consideration will have to be given by the Designated Person, Chief Executive or the Chair to immediate suspension from work. The suspension and subsequent investigation will be conducted under the Trust's Disciplinary Procedure(s) and guidelines and if, as a result of the investigation there is a case to be answered and it is deemed appropriate for formal disciplinary action, a Disciplinary Hearing will be convened under the Trust Disciplinary Procedure and as appropriate maintaining high professional standards for Medical staff. In other cases the investigation will be carried out in accordance with the principles, time periods and rights to representation as set out in the Trust's Disciplinary Procedure and Guidelines.

6.2.6 Following the investigation the Investigation Officer(s)/Panel will produce an investigation report will report back to the Designated Officer, Chief Executive, or the Chair as appropriate, who will implement the recommendations and ensure appropriate action is taken which may include changes in practise or disciplinary action. Where applicable, to ensure consistency, the Investigating Officer(s) will present the case at a Disciplinary Hearing. Otherwise the Presenting Officer(s) for any Disciplinary Hearings will be convened in accordance with the normal Disciplinary arrangements, will be fully briefed and be provided with the complete investigation report so that the case can be presented to the Disciplinary Panel.

6.2.7 If there is no case to answer the Chief Executive, Chair or Designated Person will take into account that protection should be afforded to an employee who was not in an informed position to form a belief on reasonable grounds about the truth of information, but believed nonetheless that the information may have been true and is of sufficient importance to justify its disclosure so that the truth can be investigated.

6.2.8 The Chief Executive, Chair or Designated Officer may conclude in circumstances where false or malicious allegations have been made that it is appropriate to invoke the Disciplinary Procedure against the person or persons who made these.

6.2.9 The Designated Person will provide the individual who raised the concerns with as much feedback on the outcome of the investigation as is proper in the circumstances. However, the Trust may not be in a position to disclose the precise action taken where it would infringe a duty of confidence owed to someone else. In particular precise details of any disciplinary action will not be provided.

7. ROLE OF TRADE UNIONS & OTHER ORGANISATIONS

7.1 All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

8. EXTERNAL CONTACTS

8.1 The Trust hopes this Policy reassures staff of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light. Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the Police, the Trust would hope that the robust implementation of this Policy will reassure staff that they can raise such concerns internally in the first instance.

9. OMBUDSMAN

9.1 The Ombudsman may investigate complaints by staff on behalf of a patient, provided he/she is satisfied there is no one appropriate, such as an immediate relative, to act on the patient's behalf.

Contact Number – 028 9023 3821

10. MEMBERS OF PARLIAMENT/MLA'S/EXTERNAL AGENCY

10.1 A member of staff has the right to consult with their Member of Parliament, Member of the Legislative Assembly in Northern Ireland or relevant agency. However the Trust expects staff to follow these procedures before taking such a step so that the Trust has the opportunity to take appropriate action.

11. THE MEDIA

11.1 Staff who feel their concerns have not been properly addressed through the procedure may be considering going to the media. However staff should carefully consider what they are putting into the public domain and ensure that patient confidentiality is protected at all times. The Trust reserves the right to take disciplinary action if patient confidentiality is breached.

11.2 Communication with the media is coordinated by the Communications Department. Staff approached by the media should direct the media to the Trust's telephone number 028 90960096.

12. PATIENT & CLIENT CONFIDENTIALITY – RESPONSIBILITY OF ALL STAFF

12.1 All Trust staff have a duty of confidentiality to patients and clients. Unauthorised disclosure of personal or confidential information about a patient or client is a serious matter which will result in disciplinary action. This may apply even if staff members believes he/she is acting in the best interests of a patient or client by disclosing the information. Employees have a duty of confidentiality. Breach of the duty may result in disciplinary action. Staff should seek specialist advice to ensure cases involving disclosure of confidential information are soundly based before considering action.

Belfast Health and Social Care Trust

Reference No: TP022/08

Title:	Whistleblowing Policy		
Author(s)	Claire Cairns : Head of Office of Chief Executive Tel : [redacted] – [redacted] Joan Peden : Co-Director, Workforce Governance, Employment Equality and Improving Working Lives Tel : [redacted] - [redacted] Nicola Williams : Accounting and Financial Services Tel : [redacted] – [redacted]		
Ownership:	Dr Cathy Jack, Medical Director		
Approval by:	Policy Committee Executive Team	**Approval date:**	20/5/2013 22/5/2013
Operational Date:	June 2013	**Next Review:**	June 2016
Version No.	2.1	**Supercedes**	V1-September 2009-2012
Links to other policies	http://intranet.belfasttrust.local/policies/Pages/Policies/Finance.aspx.		

Date	**Version**	**Author**	**Comments**
09/08	1	Paul Ryan/ Joan Peden	
09/01/2013	1.1	June Champion	Initial Draft
14/02/2013	1.2	Nicola Williams	Bribery Act 2012
15/02/2013	1.3	Joan Peden	Revised Draft
15/02/2013	1.4	June Champion	Revised Draft
18/02/2013	1.5	Policy Committee	Comments
01/05/2013	1.5	Workforce, Governance and Policy Review Subcommittee	No Comments
16/10/2014	2.1	Jill Shaw-O'Doherty	Revised details relating to the Head of Office and Medical Director.

Belfast Health and Social Care Trust

1.0 INTRODUCTION

1.1 The Term "whistleblowing" refers to the disclosure by employees, of wrong doing including fraud, financial irregularity, serious maladministration arising out of improper conduct, unethical activities which may be of a criminal nature or acts or omissions which create a risk to the health and safety within the Organisation to which we belong.

This policy has been developed in recognition of the fact that individual members of staff in the Belfast Health & Social Care Trust have a right and a duty to raise with the Trust any matter of concern that they may have.

The policy seeks to encourage staff to use internal mechanisms, in the first place, at an early stage and in the right way.

1.2 Suspected Fraud

If your concern is about a possible fraud you should also refer to our Fraud Policy Statement and Fraud Response Plan which can be found at http://intranet.belfasttrust.local/policies/Pages/Policies/Finance.aspx. Should you wish to report any concerns or allegations in respect of suspected fraud you can contact the Trust's Fraud Liaison Officer on Tel: 028 9082 1311, Email: fraud@belfasttrust.hscni.net or alternatively ring the confidential HSC Fraud Hotline on Tel: 08000 96 33 96.

The Bribery Act 2010, which became effective from 1 July 2011, has introduced new statutory offences for activities in the public or private sector including a new corporate offence. It also places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place.

Under the Bribery Act 2010, it is an offence to:

- Pay bribes – to offer or give a financial or other advantage with the intention of inducing that person to perform a relevant function or activity improperly or to reward that person for doing so.
- Receive bribes – to receive a financial or other advantage intending that a relevant function or activity should be performed improperly as a result.
- 'Relevant function or activity' includes any function of a public nature and any activity connected with a business.
- Fail to prevent bribery – an organisation is guilty of an offence if Trust personnel or a third party connected to it bribes another person intending to obtain or retain business or a business advantage.

The prevention, detection and reporting of bribery and other forms of corruption are the responsibility of all those working for the Trust or under its control. The Trust expects all personnel and third parties to perform their duties impartially, honestly, with integrity, and in good faith.

1.2.1 The policy takes account of the Public Interest Disclosure (NI) Order 1998 and Circular HSS (Gen) 1/2000. It does not affect existing complaint procedures and it complements professional and ethical rules, guidelines and codes of conduct relating to complaints and freedom of speech.

1.2.2 Public Interest Disclosure (NI) Order

This policy and procedure has been introduced in compliance with the provisions of the above order which took effect 31 October 1999. The order gives significant statutory protection to employees who disclose information reasonably and responsibly in the public interest. It sets out the circumstances in which disclosures of information are protected. To be protected under the law an employee must act in good faith with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may also be made to certain prescribed persons or bodies external to the Trust listed in the order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

The Trust Medical Director is the designated Executive responsible for ensuring the appropriate protections are applied. The Head of Office is the Designated Person to be the initial point of contact for complaints under this Procedure.

Staff are expected to treat many matters confidentially however the Trust does not operate any policy or clause in employee contracts which prevent staff from raising issues of concern protected by the Order. Where staff raise genuine, but unfounded concerns they will not face disciplinary action. Disciplinary action would only be considered if the disclosure was made in bad faith e.g. falsely or maliciously or in pursuit of a personal grudge.

If a member of staff is penalised or victimised for making a protected disclosure he or she can bring their case to an industrial tribunal. However the Trust has agreed that it expects staff to raise concerns about malpractices and that deterring someone from using the procedure or victimising someone who does will be viewed as a disciplinary matter.

1.3 Objectives

1.3.1 The aim of the Policy is to promote a culture of openness, transparency and dialogue which at the same time: -

- reassures staff that they will not be penalised for raising a genuine concern and gives them a process to follow
- upholds patient confidentiality
- does not unreasonably undermine confidence in the service
- meet the obligations of staff to their employer
- Contribute towards improving services provided by the Trust

The Objectives of the Procedure: -

- Encourage staff to raise matters of concern internally and advise on how the matter should be raised:
- Provide an effective and confidential process by which staff can raise genuine concerns so that patients, clients and the public can be safeguarded
- Ensure staff have the opportunity of free speech without fear of victimisation, reprisal or reproach from the Trust Board or its Management
- Assist in the prevention of fraud and mismanagement
- Demonstrate to staff and the public that the Trust is ensuring its affairs are carried out ethically, honestly and to high standards

The Trust recognises that employees may wish to contact outside bodies, however, the Trust would encourage staff to use the internal process set out in this policy.

2.0 SCOPE OF THE POLICY

2.1 The Trust recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way. The Whistleblowing Policy provides a procedure for staff to raise genuine concerns internally on malpractice relating to criminal activity, failure to comply with a legal duty, miscarriages of justice, danger to health and safety or the environment and the concealment of any of these issues in the workplace.

Examples may be: -

- Malpractice or ill treatment of a patient by a member of staff
- Repeated ill treatment of a patient despite a complaint being made
- Where a criminal offence has been committed, is being committed or is likely to be committed
- Suspected fraud
- Disregard for legislation, particularly in relation to Health and Safety at Work
- The environment has been, or is likely to be, damaged
- A miscarriage of justice has occurred, is occurring, or is likely to occur
- Breach of Standing Financial Instructions
- Showing undue favour over a contractual matter or to a job applicant
- Research misconduct
- Information on any of the above has been, is being, or is likely to be concealed

This list is not intended to be exhaustive or restrictive.

2.2 The policy is not intended for personal issues that should be properly raised under existing Grievance Procedure arrangements.

2.3 This policy compliments professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allows questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

3.0 ROLES/RESPONSIBILITIES

3.1 The Trust

- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honest and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.

3.2 Managers

- To take any concerns reported to them seriously and consider them fully and fairly
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the Trust where appropriate
- To invoke the formal procedure and ensure the designated officer is informed, if the issue is appropriate

3.3 All Members of Staff

- To recognise that it is their duty to draw to the Trust's attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain their duty of confidentiality to patients and the Trust and consequently, where any disclosure of confidential information is to be justified, the employee should first, where appropriate, seek specialist advice from for example a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical Council.

3.4 Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

3.5 Ombudsman

The Ombudsman may investigate complaints by staff on behalf of a patient, provided he/she is satisfied there is no one appropriate, such as an immediate relative, to act on the patient's behalf.

Contact Number – 028 9023 3821

Belfast Health and Social Care Trust

4.0 POLICY STATEMENT ON WHISTLE BLOWING AT WORK

The Belfast Health & Social Care Trust is committed to achieving the highest possible standards of service and the highest ethical standards in all its practices. To achieve these ends it promotes openness and encourages staff to speak freely and contribute their views on health and social care activities especially those relating to the delivery of care to patients and clients.

In introducing the Whistle Blowing Policy the Trust strives to encourage a climate of honesty and openness in which it is safe and acceptable for any member of staff to raise concerns internally and at the earliest possible time.

Staff are recommended to use internal procedures for reporting genuine concerns regarding malpractice or illegal acts at work by Trust employees. When genuine concerns have been raised in good faith, staff in accordance with this procedure will be protected against victimisation or any other detrimental treatment related to their act of disclosure.

The Trust Board and Chief Executive are fully committed to this Policy and its implementation.

POLICY STATEMENTS

4.1 External Contracts

The Trust hopes this Policy reassures staff of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light. Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the Police, the Trust would hope that the robust implementation of this Policy will reassure staff that they can raise such concerns internally in the first instance.

4.2 Members of Parliament/Members of Parliament/MLA's/External Agency

A member of staff has the right to consult with their Member of Parliament, Member of the Legislative Assembly in Northern Ireland or relevant agency. However the Trust expects staff to follow these procedures before taking such a step so that the Trust has the opportunity to take appropriate action.

4.3 The Media

Staff who feel their concerns have not been properly addressed through the procedure may be considering going to the media. However staff should carefully consider what they are putting into the public domain and ensure that patient confidentiality is protected at all times. The Trust reserves the right to take disciplinary action if patient confidentiality is breached.

Communication with the media is coordinated by the Communications Department. Staff approached by the media should direct the media to the Trust's telephone number 028 90960096.

Belfast Health and Social Care Trust

4.4 Patient and Client Confidentiality – Responsibility of all Staff

All Trust staff have a duty of confidentiality to patients and clients. Unauthorised disclosure of personal or confidential information about a patient or client is a serious matter which will result in disciplinary action. This may apply even if staff members believes he/she is acting in the best interests of a patient or client by disclosing the information. Employees have a duty of confidentiality. Breach of the duty may result in disciplinary action. Staff should seek specialist advice to ensure cases involving disclosure of confidential information are soundly based before considering action.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy will be circulated to all staff.

5.2 Resources

This policy will be available on the Hub

5.3 Exceptions

None

6.0 MONITORING

Reports will be monitored within the Chief Executive's office.

7.0 EVIDENCE BASE / REFERENCES – list legislation

- DHSSPS Circular Ref HSS(F)07/2009

8.0 CONSULTATION PROCESS

- Governance Steering Group
- Workforce, Governance and Policy Review Subcommittee
- Finance Governance

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Procedure
Appendix 2 - Minister of Health Letter of 22 March 2012

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. X

Belfast Health and Social Care Trust

SIGNATORIES

______________________________ **Date: 22 May 2013**

Name Colm Donaghy
Title Chief Executive

______________________________ **Date: 22 May 2013**

Name Professor Eileen Evason
Title Chairman

Belfast Health and Social Care Trust

Appendix 1
PROCEDURE

1.1 Informal Procedure

If an employee has a genuine concern about what they believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with their Line Manager, or if there are specific reasons for not doing so the matter should be reported to the appropriate Senior Manager/Director.

1.2 Employees are entitled to representation from a Trade union/fellow worker or companion in assisting them raise such a matter of concern.

1.3 If the concern can be resolved at a local level, then the Line Manager will take the appropriate action and the staff member will be notified of the action taken within five working days of having raised the concern. If additional time is needed the timescale will be reviewed and communicated.

Where action is not considered practicable or appropriate the staff member should be provided with an explanation of the reasons within the timescale or revised timescale.

1.4 If informal action does not allay concerns, then the employee should invoke the formal procedure outlined below.

1.5 Where appropriate the Manager may decide to refer the issue to the Trust Designated Person to be dealt with under the formal procedure below).

2 Formal Procedure

In the event that the matter raised cannot be dealt with informally or under any of the Trusts other Procedures for dealing with conduct and behaviour at work, as specified at paragraph 3, then the following Procedure should be invoked:-

2.1 The Trust has appointed a Designated Person to be the initial point of contact for complainants under this Procedure. The Designated Person will have direct access to the Chair/Chief Executive. In some situations a member of staff may have initially discussed the matter with their Line Manager. It is important that the matter is immediately brought to the attention of the Designated Person.

Designated Person:	Mrs Claire Cairns
Title:	Head of Office
Location:	Chief Executive's Office
Telephone Number:	028 95040114

2.2 The Designated Person will arrange an initial interview with the complainant, which will be strictly confidential and will ascertain the area of concern. The complainant may be represented by a Trade Union representative or fellow worker/companion. The Designated Person will seek to reassure the complainant about protection from possible reprisals or victimisation and give them a copy of this Policy. The Designated Person will write a summary report of the interview which will be agreed by both parties, and will ask the complainant to make a written statement.

2.3 The Designated Person will report to the Chief Executive. However, if the complaint is about the Chief Executive the Designated Person should report to the Chair. In the event the complaint is about the Chair of the Trust it should be referred to the Permanent Secretary, Department of Health, Social Services & Public Safety. If the complaint concerns the improper use of public funds then the Designated Person should have direct access to the Chair of the Trust's Audit Committee.

2.4 The Chief Executive, or the Chair or Designate Person as appropriate, will be responsible for the commission of the investigation. This investigation will be carried out by an independent individual(s) (Investigating Officer(s))/Panel. The Investigating Officer(s)/Panel will conduct a full investigation which will be carried out under the terms of strict confidentiality. The Designated Person will be kept informed of progress.

2.5 In serious cases, for example allegations of ill treatment of patients, fraud, consideration will have to be given by the Designated Person, Chief Executive or the Chair to immediate suspension from work. The suspension and subsequent investigation will be conducted under the Trust's Disciplinary Procedure(s) and guidelines and if, as a result of the investigation there is a case to be answered and it is deemed appropriate for formal disciplinary action, a Disciplinary Hearing will be convened under the Trust Disciplinary Procedure and as appropriate maintaining high professional standards for Medical staff. In other cases the investigation will be carried out in accordance with the principles, time periods and rights to representation as set out in the Trust's Disciplinary Procedure and Guidelines.

2.6 Following the investigation the Investigation Officer(s)/Panel will produce an investigation report will report back to the Designated Officer, Chief Executive, or the Chair as appropriate, who will implement the recommendations and ensure appropriate action is taken which may include changes in practise or disciplinary action. Where applicable, to ensure consistency, the Investigating Officer(s) will present the case at a Disciplinary Hearing. Otherwise the Presenting Officer(s) for any Disciplinary Hearings will be convened in accordance with the normal Disciplinary arrangements, will be fully briefed and be provided with the complete investigation report so that the case can be presented to the Disciplinary Panel.

2.7 If there is no case to answer the Chief Executive, Chair or Designated Person will take into account that protection should be afforded to an employee who was not in an informed position to form a belief on reasonable grounds about the truth of information, but believed nonetheless that the information may have been true and is of sufficient importance to justify its disclosure so that the truth can be investigated.

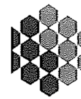
2.8 The Chief Executive, Chair or Designated Officer may conclude in circumstances where false or malicious allegations have been made that it is appropriate to invoke the Disciplinary Procedure against the person or persons who made these.

2.9 The Designated Person will provide the individual who raised the concerns with as much feedback on the outcome of the investigation as is proper in the circumstances. However, the Trust may not be in a position to disclose the precise action taken where it would infringe a duty of confidence owed to someone else. In particular precise details of any disciplinary action will not be provided.

Belfast Health and Social Care Trust

Appendix 2 – Ministers letter

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 90 520642
Fax: 028 90 520557
Email: private.office@dhsspsni.gov.uk

For Action:

Chief Executives of HSC Bodies[1]; Chief Fire Officer

For information:

Director of Human Resources of each body

Our Ref: SUB/325/2012

22 March 2012

Dear Colleague

Please bring the content of this letter to the attention of all your employees, and make available with it your whistleblowing policy.

MESSAGE FROM EDWIN POOTS

YOUR RIGHT TO WHISTLE BLOW

1. I am committed to the highest possible standards of conduct, openness, honesty and accountability in our Services. In line with that commitment I expect staff to act on any genuine concerns they might have about any aspect of an organisation's work or colleagues, in the knowledge that such action has support from the highest level. I want every member of staff to be very confident that managers at all levels will respond positively to expressions of concern, and that, should it be necessary, you will be protected from victimisation if you make a genuine concern known under the whistleblowing arrangements.

You have the right to be heard by management if you have concerns about any ethical or safety issue, and a responsibility to speak up

2. The first kind of action that is appropriate is to speak up within your team or to the appropriate manager. The principles of clinical and social care governance empower all staff to speak up if they see or become aware of practice which is unsafe or which creates unacceptable risks to patients or clients.

[1] The Health and Social Care Board, HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, the Northern Ireland Guardian ad Litem Agency, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

Working for a Healthier People

It is the responsibility of any member of staff who is challenged on that basis to give proper consideration to the points being made by any colleague.
Similar principles should apply in all the other aspects of our services away from the clinical or social care front line. Managers and leaders at all levels are responsible for creating and sustaining an atmosphere of mutual support, mutual learning, and conduct based on the priority of the quality and safety of services and the health, well-being and dignity of the patients, clients, family members and carers whom we all serve. By far the most important concern for me, and for all who lead and manage HSC organisations, all DHSSPS' Arms Length Bodies and the Department itself, is to ensure that we provide the best possible services to patients, clients, and the wider public, and I am sure you share that commitment.

If speaking up is a problem, whistleblowing is both your right and your duty

3. If you have any concern that speaking up in good faith in the way I have described would lead to a problem, there are statutory procedures that protect you if you chose to blow the whistle and draw attention to something that is a cause for concern. All HSC staff have a moral duty to pass on any concerns to someone who can deal with it. I should therefore personally encourage you to speak up where you have genuine concerns about issues such as patient safety or possible malpractice in your workplace and reassure you that genuine concerns will be resolved quickly and effectively.

4. There is a common misconception that whistle blowing is solely fraud related. In effect whistle blowing can be wide ranging covering issues around health and safety e.g. unsafe products or working conditions.

5. Whistle blowing refers to "making a disclosure in the public interest" and it means that concerns relating to unlawful conduct, financial malpractice, dangers to the public or the environment, or actions otherwise contrary to the public interest can be reported in the workplace following the correct procedures and protecting employment rights. There should be an established whistle blowing policy and procedure within your organisation which should be followed for reporting your concerns.

6. I fully recognise that the decision to report a concern can be a difficult one to make. However, if what you are saying is true, you should have nothing to fear because you will be doing your duty to your employer and those for whom you provide a service.

7. I will not tolerate any harassment or victimisation (including informal pressures) and will take appropriate action to protect you when you raise a concern in good faith. If you report concerns reasonably and in good faith you are also formally protected against victimisation under The Public Interest Disclosure (Northern Ireland) Order 1998 (revised 2004).

8. Your organisation's whistleblowing policy sets out how to go about expressing a concern both internally and, should it be necessary, outside line management. Each organisation's policy should make it clear that ultimately, you have the right to direct your concern to me.

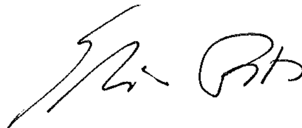
Belfast Health and Social Care Trust

Confidentiality of personal information about patients, families and members of staff must be protected

9. If you need to make a disclosure in the public interest it is important to be mindful of the need to avoid a breach of the privacy and confidentiality of personal information. It is wrong to give details of the condition or treatment of any patient or client without their explicit consent. Also, personnel records are protected by Data Protection legislation, and there are procedures for investigation and accountability of all staff in the HSC, in ALBs or within DHSSPS as part of the NI Civil Service, which should not be prejudiced or undermined by public or any other inappropriate disclosures of information. There are independent watchdog organisations, including the Northern Ireland Audit Office and the Regulation and Quality Improvement Authority which have specific duties to investigate confidential disclosure while protecting the person making the disclosure. The Patient and Client Council exists to act in the interests of patients and clients and to help with complaints. Where the duty to protect personal information is broken, it is sometimes necessary to investigate, however, any such investigation process should create no difficulty and hold no fear for anyone acting to disclose legitimate concerns in the public interest, as described above.

Conclusion

10. Finally, I would like to encourage you to feel confident in raising concerns and to question and act upon genuine concerns that you may have in relation to your workplace. This is a vital element of good public service based on the values and principles that are at the heart of Health and Social Care and all the related organisations.



Edwin Poots MLA
Minister for Health Social Services and Public Safety

Working for a Healthier People

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 22/08

Title:	**Your right to raise a concern (Whistleblowing) Policy**			
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1.0 BACKGROUND & PURPOSE OF POLICY

Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

Encouraging staff to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage, corrective action can be put in place to ensure safe, high quality and compassionate care.

The importance of raising concerns at work in the public interest (or "whistleblowing") is recognised by employers, workers, trade union and the general public. Working in partnership with Trade Unions, staff associations and employee representatives is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place.

1.1 Defining Whistleblowing

Whistleblowing is defined as "when a worker reports suspected wrongdoing at work".

The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences.

Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:

- patient safety;
- health and safety at work;
- environmental damage; or
- a criminal offence (e.g. fraud).

Whistleblowing can also be broadly defined as simply 'raising a concern'. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the HSC Complaints Procedure. However, whistleblowing is different from making a complaint or raising a grievance.

Whistleblowers can often act out of a feeling of fairness or ethics rather than a personal complaint. As Public Concern at Work (PcAW) states, it is important to note that:

"....*the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not*

be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it".

1.2 Overview

This applies to **all staff** (employees, workers) involved in the work of BHSCT. It does not apply to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by BHSCT or about issues relating to the provision of health and social care. These will be dealt with under the separate BHSCT Complaints Procedure.

This is for staff to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their personal position they must follow the local grievance procedure for making a complaint about Bullying and/or Harassment.

All cases of suspected, attempted or actual fraud raised under this policy should be handled promptly in line with the organisation's Fraud Response Plan

It is important that BHSCT, like all HSC organisations are committed to the principles set out in their whistleblowing arrangements and can ensure that it is safe and acceptable for staff to speak up about wrongdoing or malpractice within their organisation.

Within BHSCT

- Head of Office has been identified to take responsibility for ensuring implementation of the whistleblowing arrangements.

- For each Directorate advisors/advocates have been identified to signpost and provide support to those wishing to raise a concern.**(Ref Appendix D)**

- A non-executive board member has been identified to have responsibility for oversight of the culture of raising concerns within their organisation.

As an employer, BHSCT must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. BHSCT Head of Office / Directorate Advocate will consider a range of possibilities depending on the nature of each case:

- explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
- minor concerns might be dealt with straightaway by line management
- a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
- there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
- there may be a clear need for a formal investigation.

Having considered the options it is important that the rationale for the way forward is clearly documented. If necessary, the BHSCT can also seek advice and guidance from the relevant prescribed person.

1.3 BHSCT Procedure for Whistleblowing

1.3.1 Introduction

All of us at one time or another may have concerns about what is happening at work. The BHSCT wants you to feel able to raise your concerns about any issue troubling you with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or BHSCT itself, it can be difficult to know what to do.

The BHSCT recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged.

This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof, raise the matter when it is still a concern. If something is troubling you of which you think we should know about or look into, please let us know. The BHSCT has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

1.3.2 Aims and Objectives

BHSCT is committed to running the organisation in the best way possible. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the BHSCT;
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the BHSCT is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

The BHSCT roles and responsibilities in the implementation of this policy are set out at **Appendix A** of this Policy.

2.0 SCOPE

The BHSCT recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of the BHSCT, including permanent, temporary and bank staff, staff in training working within the BHSCT, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think BHSCT should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow the BHSCT's local grievance procedure, Working Well Together Policy or Harassment Policy which can be obtained from your manager. This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to

replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

3.0 ROLES & RESPONSIBILITIES

Refer **Appendix A**

4.0 KEY POLICY PRINCIPLES

4.1 Suspected Fraud

If your concern is about possible fraud or bribery BHSCT has a number of avenues available to report your concern. These are included in more detail in BHSCT Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Senior Manager
- Head of Department
- Director of Finance
- Fraud Liaison Office (FLO)

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The BHSCT's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the BHSCT or under its control.

The BHSCT expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

4.2 BHSCT Commitment to you

4.2.1 Your Safety

The BHSCT, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The BHSCT will

not tolerate the harassment or victimisation of anyone who raises a genuine concern.

The BHSCT expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and the BHSCT reserves the right to take disciplinary action if appropriate.

4.2.2 Confidentiality

With these assurances, the BHSCT hopes that you will raise concerns openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to initially a member of staff within your Directorate that has been identified to provide support in relation to Whistleblowing.

(Ref **Appendix D** for details of BHSCT Directorate Advocates)

The BHSCT is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

4.2.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice 4.3.2).

4.3 Raising a concern

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in 4.4. You should also remember that you do not need to

have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

4.3.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). But where you do not think it is appropriate to do this, you can use any of the options set out below. If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact:

- the designated advisor/ advocate (**Ref Appendix D**)

If you still remain concerned after this, you can contact:

- Claire Cairns Head of Office **(Ref Appendix D)**

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see 4.4 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

4.3.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation. Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

4.3.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

4.4 Raising a concern externally

The BHSCT hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the BHSCT would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the BHSCT recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health;
- A prescribed person, such as:
  - o General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland, General Optical Council
  - o The Regulation and Quality Improvement Authority;
  - o The Health and Safety Executive;
  - o Serious Fraud Office,
  - o Her Majesty's Revenue and Customs,
  - o Comptroller and Auditor General;
  - o Information Commissioner
  - o Northern Ireland Commissioner for Children and Young People
  - o Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

4.5 The Media

You may consider going to the media in respect of their concerns if you feel the BHSCT has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. The BHSCT reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by Corporate Communications on behalf of the BHSCT. Staff approached by the media should direct the media to this department in the first instance.

4.6 Conclusion

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the BHSCT listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

4.7 Equality, Human Rights & DDA

The BHSCT This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the BHSCT to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.
The policy has been **screened out** without mitigation.

4.8 Alternative Formats

The document that this Policy is based on can be made available on request on disc, larger font, Braille, audiocassette and in other minority languages to meet the needs of those who are not fluent in English.

4.9 Sources of advice in relation to this document

The Policy Author, Head of Office or Directorate Advocates (as per Appendix D) should be contacted with regard to any queries on the content of this policy.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This is applicable to all staff. In addition to the Head of Office and Directorate Advocates, Senior Managers play a vital role in ensuring all staff are aware of the arrangements within the Trust.

5.2 Resources

Public Concern at Work (PCaW) have delivered training to key staff within the Trust

6.0 MONITORING

Details regarding Whistleblowing will be maintained by the Head of Office

7.0 EVIDENCE BASE / REFERENCES

- Your Right to raise a Concern (Whistleblowing) HSC Framework & Model Policy (02 Nov 2017)
- Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)
- Government Whistleblowing Policies National Audit Office (2014)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
- Where's whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010
- Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work
- Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
- Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996
- The Public Interest Disclosure (Northern Ireland) Order 1998
- Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014
- The Employment Rights (Northern Ireland) Order 1996 as amended by the Employment Act (Northern Ireland) 2016
- Department of Health. Correspondence from Health Minister Ref SUB/325/2012 (02 Mar 2012)

8.0 CONSULTATION PROCESS

This policy has been taken from the Regional framework that has been agreed after regional consultation including Northern Ireland HSC organisations and Trade union representation.

9.0 APPENDICES / ATTACHMENTS

Appendix	Details
A	Roles and Responsibilities
B	Procedure for raising a concern
C	Advice for Managers responding to a concern
D	Key contacts within BHSCT
E	Flowchart for raising concerns & whistleblowing process

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. ☒

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Date: 4 April 2017

Dr Cathy Jack,
Deputy Chief Executive/Medical Director

Date: 4 April 2017

Martin Dillon
Chief Executive

Appendix A Roles and Responsibilities

The BHSCT

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via organisations shared learning Procedures

The non executive director (NED)

- To have responsibility for oversight of the culture of raising concerns within their organisation

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements

Managers

- To take any concerns reported to them seriously and consider them fully and fairly
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the BHSCT where appropriate
- To invoke the formal procedure and ensure the Head of Office is informed, if the issue is appropriate
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations
- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns

This list is not intended to be exhaustive or restrictiv

All Members of Staff

- To recognise that it is your duty to draw to the BHSCT attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the BHSCT and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

Appendix B Procedure for raising a Concern

Step one (Informal)

If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager (lead clinician or tutor). This may be done verbally or in writing.

You are entitled to representation from a trade union/ fellow worker or companion to assist you in raising your concern.

Step two (informal)

If you feel unable to raise the matter with your Line Manager (lead clinician or tutor), for whatever reason, please raise the matter with the designated adviser/ advocate for your Directorate (Ref **Appendix D** for further details)

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed;
- ensure you receive timely support to progress your concerns;
- escalate to the Head of Office any indications that you are being subjected to detriment for raising your concern;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;
- ensure you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three (formal)

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

Claire Cairns Head of Office directly (Ref **Appendix D** for details)

Step four (formal)

You can raise your concerns formally with the external bodies listed in 4.4

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of the BHSCT to take forward the investigation in conjunction with the Agency if appropriate.

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under the BHSCT Whistleblowing Policy.

Communicating with you

We welcome your concerns and will treat you with respect at all times. We will

discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant professional Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

Board oversight

The BHSCT board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a non-executive director with responsibility for the oversight of the organisation's culture of raising concerns.

Review & Reporting

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate.

We will provide regular reports to senior management and to our Audit Committee on our whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

Appendix C - Advice for managers responding to a concern

1. Thank the staff member for raising the concern, even if they may appear to be mistaken;

2. Respect and heed legitimate staff concerns about their own position or career;

3. Manage expectations and respect promises of confidentiality;

4. Discuss reasonable timeframes for feedback with the member of staff;

5. Remember there are different perspectives to every story;

6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;

7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager);

8. Managers should bear in mind that they may have to explain how they have handled the concern;

9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;

10. Consider reporting to the board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed; and

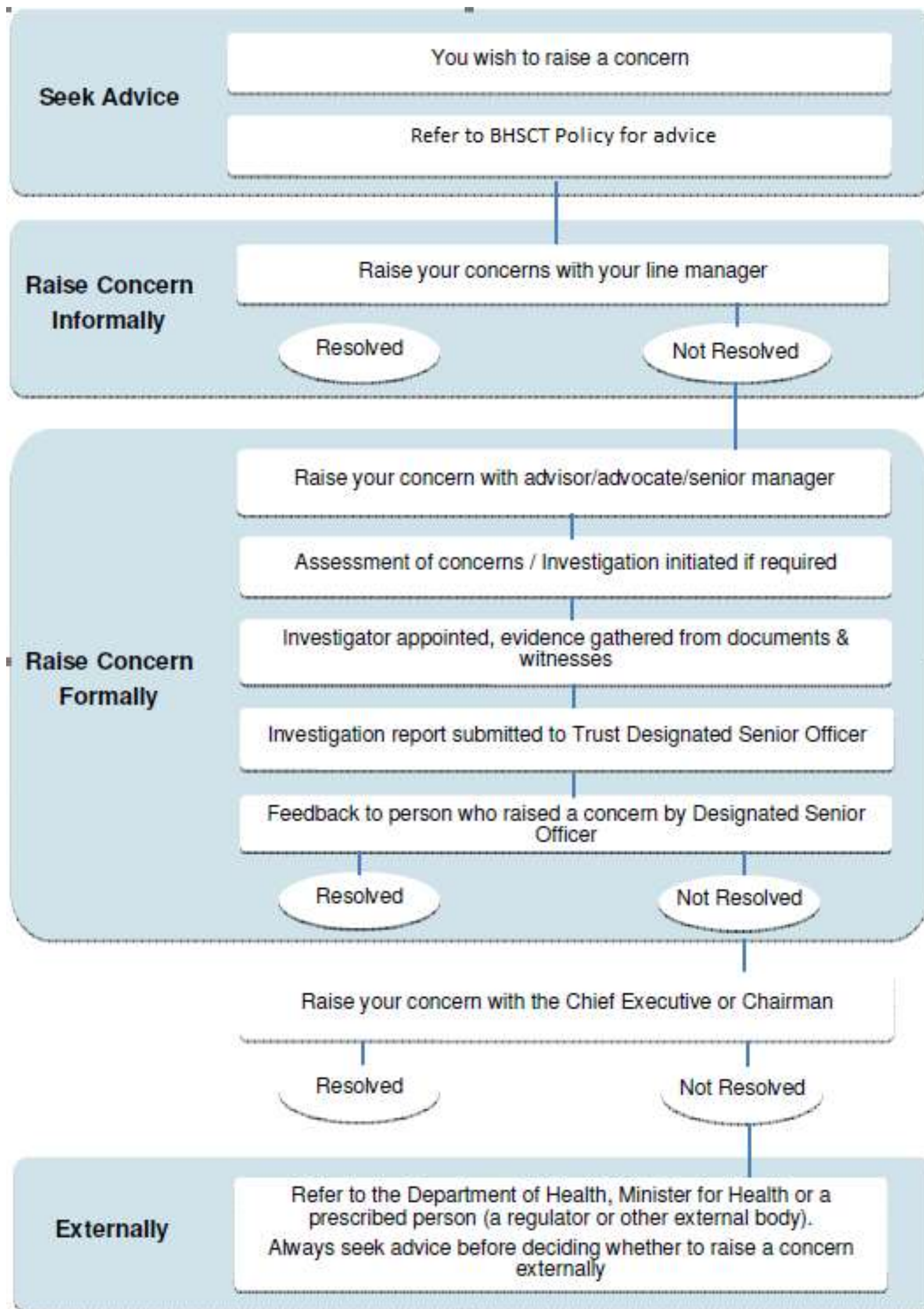
11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary.

Appendix D – Key contacts within BHSCT

The following table outlines staff within BHSCT that have been identified to provide further advice / guidance in relation to whistleblowing

	Name	Email Address	Phone Number
Head of Office	Claire Cairns	[redacted]	[redacted]
Directorate	**Advocate**	**Email Address**	**Phone Number**
Adult Social & Primary Care	Ursula McCollam	[redacted]	[redacted]
	Catherine Collins	[redacted]	[redacted]
Children's Community Service	Nuala C Toner	[redacted]	[redacted]
	Kerry Lee Weatherall	[redacted]	[redacted]
	Cathy Curry	[redacted]	[redacted]
Finance, Estates Services & Capital Redevelopment	Nicola Williams	[redacted]	[redacted]
	Damian Horisk	[redacted]	[redacted]
	Fiona Cotter	[redacted]	[redacted]
Human Resources & Organisation Development	Joan Lowry	[redacted]	[redacted]
	Martin McGrath		
	Marie Curran	[redacted]	[redacted]
	Sally Thompson	[redacted]	[redacted]
	Claire Nellis	[redacted]	[redacted]
	Alison Kerr		
Nursing & User Experience	Seamus Trainor	[redacted]	[redacted]
	Karen Devenney	[redacted]	[redacted]
	Paula Forrest	[redacted]	[redacted]
	Aisling Pelan	[redacted]	[redacted]
	Tony McDonagh	[redacted]	[redacted]
Specialist Hospitals and Women's Health	Patricia McKinney	[redacted]	[redacted]
	Brenda Kelly	[redacted]	[redacted]
Surgery & Specialist Services	Sharon ODonnell	[redacted]	[redacted]
	Debbie Wightman	[redacted]	[redacted]
	Clodagh Loughrey	[redacted]	[redacted]
Unscheduled & Acute Care	Liz McAlea		
	Bernie Carey		
	Tara Clinton	[redacted]	[redacted]
	Margaret Reid	[redacted]	[redacted]
	Jane Sheridan		
Medical Directorate	Peter Watson	[redacted]	[redacted]
	Robert Henry	[redacted]	[redacted]
Performance, Planning & Informatics	Gillian Acheson	[redacted]	[redacted]
	Stephen Best	[redacted]	[redacted]

Appendix E Flowchart - Raising Concerns & Whistleblowing Process



RQIA Guidance for Whistleblowers

Guidance for health and social care staff who wish to make a protected disclosure about wrongdoing in their workplace.

October 2018 (updated June 2021)

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RQIA Guidance for Whistleblowers

1 What is Whistleblowing?

The term whistleblowing is used to describe a situation where a worker makes a protected disclosure about wrongdoing in their workplace. This can be reported as a protected disclosure to a prescribed body, and their employment rights will be protected.

This guidance has been developed for the benefit of staff who work in all health and social care bodies and those who work in registered establishments.

2 What is a Protected Disclosure?

Workers who are concerned about wrongdoings or failures can make disclosures to a prescribed body[1] for example, RQIA. For a disclosure to be protected by the Public Interest Disclosure (Northern Ireland) Order 1998 (Amended January 2011) the worker must:

- make the decision in good faith, which means with honest intent and without malice
- reasonably believe that the information, and any allegation it contains is substantially true, and
- reasonably believe that they are making the disclosure to the correct/appropriate 'specified person'

3 Qualifying Disclosures

Certain kinds of disclosures qualify for protection. If a worker believes that one or more of the following is happening now; took place in the past; or, is likely to happen in the future; they can report these to a prescribed body:

- a criminal offence
- a breach of legal obligation
- a miscarriage of justice
- a danger to the health or safety of any individual
- damage to the environment
- deliberate covering up of information relating to any of the above five matters

[1] A prescribed body is one identified under the Public Interest Disclosure (Prescribed Person) (Amendment) Order (Northern Ireland) 2012 as able to receive concerns about organisations.

4 What to Do if You Have Concerns

In the first place, the worker should talk informally to their manager, or someone else in authority within their place of work. They should also follow their organisation's internal policies about reporting concerns.

Managers should deal quickly and effectively with concerns from workers about their organisation. However, if the worker has raised a concern and does not believe that management has dealt with the matter properly, they can take it further by making a protected disclosure to RQIA. Many employers have their own whistleblowing policies and procedures, which must be followed in the first instance.

If there is no whistleblowing policy, or the worker remains dissatisfied after using it, they can report their concerns to RQIA or to another prescribed body, and continue to have the protection of the law under the Public Interest Disclosure (Northern Ireland) Order 1998. (RQIA and the Northern Ireland Social Care Council (NISCC) are the prescribed bodies for health and social care in Northern Ireland.)

If a worker is employed by an agency providing services or is a volunteer or student, they may wish to discuss their concerns with their own line manager, so that they can consider what action to take.

If a worker is not confident that the management of the service (or their own management) will deal with their concerns properly, they can whistle blow directly to RQIA or NISCC.

5 How to Raise Concerns with RQIA

You can contact RQIA by telephone, email or letter. RQIA staff will ensure that the information given to us is passed to the appropriate person within the organisation, who can decide what action to take next.

Contact details for RQIA:

Telephone: (028) 9536 1990

Email: info@rqia.org.uk

Address: Regulation and Quality Improvement Authority (RQIA)
7th Floor,
Victoria House,
15-27 Gloucester Street,
Belfast BT1 4LS

Website: www.rqia.org.uk

6 What RQIA Does with Concerns

Depending on the details of the information, RQIA may do one or more of the following:

- follow up the matters raised at the next inspection
- raise the matter directly with the service provider.
- review the information to decide if it warrants an announced or unannounced inspection of the service.
- escalate in line with RQIA's enforcement policy and procedure.
- review the information in line with the Adult Safeguarding Operational Procedures, September 2016 or Co-operating to Safeguard Children and Young People in Northern Ireland.
- contact the relevant HSC trust Department of Health or the HSC Board to decide on appropriate action.
- notify another public body to lead an investigation of the concern, as appropriate, with involvement from RQIA, when required.
- notify the Police Service of Northern Ireland (PSNI) if the information is about an alleged criminal offence.

7 Anonymous Information and Confidentiality

Where a worker provides RQIA with information anonymously, and provides no contact details, we cannot invite them to discuss their concerns. Nevertheless, all anonymous information will be treated in the same manner as People who give RQIA their details.

If the worker's identity and contact details are disclosed but the information is provided in confidence, RQIA will respect the worker's request for anonymity. However, this may not be possible in every circumstance, as we may have to share information with a third party that could require the identification of the source. For example, depending on the information given to us, we may need to contact the PSNI about alleged criminal activity or another public authority under the provisions of the Protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults, or under the Regional Child Protection protocols. When these circumstances apply, the whistleblower will be advised at the time the disclosure is made.

RQIA may make direct contact with the whistleblower where contact details have been provided and it is considered necessary. RQIA is not obliged to provide whistleblowers with an account of any actions taken in response to their concerns.

8 Is Whistleblowing the Same as Making a Complaint?

Whistleblowing refers only to situations where a worker raises concerns about their place of work.

People who use services, their relatives, representatives or others can make complaints about a service, using the services' complaints policy and procedure. This is not whistleblowing. These people can also raise concerns with RQIA where they are concerned about the quality and standard of care or services being provided/offered.

Workers who are unsure if their concern is deemed a matter of whistleblowing may wish to contact RQIA for further advice of how this can be reported. Contact details are outlined under point 5.

For information on how to make a complaint about a service please see our website.

9 What Should Employers do About Arrangements for Workers to Report Concerns?

Employers should ensure they have developed their own whistleblowing policy and procedure.

Employers should ensure that workers are aware of their rights under Public Interest Disclosure Order (Northern Ireland) 1998.

Employers should ensure their workers are confident about reporting any concerns to them and/or to a prescribed body, without worrying about the consequences.

Services provided by HSC bodies and registered establishments should have an open culture that allows workers to feel supported to raise concerns, both inside and outside of the workplace, without fear of recrimination.

10 Further Information

You can read Public Interest Disclosure (Northern Ireland) Order 1998.

You may also find guidance, prepared by the Northern Ireland Audit Office, National Audit Office, Audit Scotland and Wales Audit Office, in partnership with Public Concern at Work, entitled Whistleblowing in the Public Sector, helpful.

If you wish to seek advice regarding employment matters you should contact the Labour Relations Agency (LRA) who can provide support or advice.

Contact details for LRA are as follows:

2-16 Gordon St
Belfast
BT1 2LG

Tel: 03300 552 220
Email: info@lra.org.uk

RAISING A CONCERN IN THE PUBLIC INTEREST (WHISTLEBLOWING)

HSC FRAMEWORK & MODEL POLICY

May 2022

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GLOSSARY OF TERMS

- Health and Social Care shared values – the shared values of Working Together, Excellence, Openness & Honesty and Compassion as agreed and used across the HSC Trusts.
- Whistleblowing – a term which is often used to describe raising concerns in the public interest – this term can and often is used interchangeably with the formal phrase of raising concerns in the public interest. Throughout this document the phrase raising concerns in the public interest is used however you will note that in some other referenced material whistleblowing is used.
- Raising concerns in the public interest – this term is preferred to the term Whistleblowing as it is the term referred to in the legislation. In reality both terms are used interchangeably.
- Raising Concern Advocates – persons within the Trusts who are trained to provide a range of services with respect to raising concerns in the public interest.
- All Staff and others – as this policy applies to a broad range of staff, agency workers, contractors etc. and also applies to volunteers and members of the public, the phrase 'staff and others' is used to describe the range of people who can utilise this policy. There are some legal provisions that will not apply to volunteers or members of the public and this is covered in the section on Legal Framework
- Non-Executive Director (NED) – member of the Trust Boards.
- Board – all Trusts have a Board who are constituted to perform roles on behalf of the Department of Health
- Northern Ireland Audit Office (NIAO) – the audit office for NI public sector organisations.
- Fraud Response Plan – a specific plan for dealing with allegations or actual fraud in public sector organisations.
- Public Interest – means it must affect others, i.e. the general public, however does not necessarily mean that a large number of people need to be affected or interested.
- PROTECT – an independent charity (Protect) who can be contacted for advice

At a glance – A guide to Raising Concerns in the Public Interest (also known as Whistleblowing)

- Whistleblowing may be called speaking up or raising a concern. It is all about ensuring that if someone sees something wrong in the workplace, they are able to raise this within the organisation, or to a regulator, or more widely if appropriate. Whistleblowing ultimately protects customers, staff, beneficiaries and the organisation itself by identifying harm before it's too late. Raising concerns in the public interest and whistleblowing are the same thing. Whistleblowing is the more recognisable term for raising concerns in the public interest.
- You don't have to be an employee for your concern to be considered by the Trust. You can raise a concern in the public interest if you are an agency worker, contractor, bank worker, volunteer and even a member of the public. If you are not sure if your concern should be raised under this policy you can ask one of the Trust's raising concerns advocates for advice or you can contact Protect - https://protect-advice.org.uk/ or visit the Northern Ireland Audit Office website resources. The important thing is that if you have a concern, you should feel you can raise it. Protect, a raising concerns advocate or a Trade Union rep can help you decide how to take it forward.
- Whilst the Trust would hope that you can raise you concern directly with the Trust, if you feel you can't raise your concern with the Trust there are other options available to you. You can raise your concern through a range of other organisations depending on the nature of your concern without losing your rights under whistleblowing legislation. These other organisations are listed in the legislation (https://www.legislation.gov.uk/nisr/2014/48/schedule/made) and are known as prescribed persons. The Trust would prefer you to raise your concerns with any of these external organisations listed in the legislation, rather than not raise them at all.
- There are some instances when you may consider taking your concern to the media. Whilst the Trust would hope that this policy reassures you that your concern will be taken seriously and addressed, if your complaint has not been addressed appropriately in your view and you decide to go to the media it's very important that you do not include personal information about patients.
- If you choose to bypass the routes available for you to make a disclosure (directly to the Trust or via outside organisations referred to in the legislation) and instead approach the media with your concerns, it is likely you will lose your right to protection under Whistleblowing legislation. The exception to this is a case where the wrongdoing is exceptionally serious and where you reasonably believe that the Trust will subject you to 'detriment' or conceal/destroy evidence if you were to raise your concerns via the routes available to you.

- If your complaint is personal to you then it's unlikely that it would be considered under this policy (refer to Paragraph 20 on use of Grievance Procedure). Concerns raised under this policy should be in the 'public interest'. This means that they are e.g. concerning an unlawful act, health & safety issues, abuse of children or vulnerable adults in care, damage to the environment, failing to safeguard personal and/or sensitive information, abuse of position or any deliberate concealment of information tending to show any of these things.
- The focus on public interest means that you don't have to evidence of the wrongdoing just that you have an honest belief that it is happening/taking place. It won't matter if you made a mistake.
- If you raise a concern in the public interest then you are have rights in law that you cannot be treated badly (detriment) or victimised because you made a raised a concern. This is what the legislation says…."A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure......A worker may present a complaint to an industrial tribunal that he has been subjected to a detriment." (NIAO guide page 57). This is the case where you are a worker – this means that if you are a member of the pubic this legislation isn't relevant.
- You might be worried that you will be mistreated in some way for having raised your concern. That is totally understandable. Often individuals reflect that they wish they had raised issues but were too afraid of being seen as causing trouble. The legislation that underpins this policy provides for legal protection for you if you raise a concern in the public interest. This means that if you are treated less favourably or victimised then you can take a case to an Industrial Tribunal.
- It is important to be mindful of the need to avoid a breach of privacy and confidentiality regarding personal information when making a disclosure. Details of the condition or treatment of any patient or client should not be given without their explicit consent or consent from their legal/personal representative. The same principle applies to an individual's personnel records. The requirement to comply with General Data Protection Regulations (GDPR) must be considered and complied with at all times.

INTRODUCTION

1. Health and social care services exist to promote the health, wellbeing and dignity of patients and service users and the people who deliver these services want to do the best for those they serve.

2. Encouraging staff to raise concerns in the public interest (or “whistleblowing”) openly as part of normal day-to-day practice is an important part of improving the quality of services and patient safety. Many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. When concerns are raised and dealt with appropriately at an early stage learning can take place and corrective action can be put in place to ensure safe, high quality and compassionate care.

3. The importance of raising concerns at work in the public interest is recognised by employers, workers, trade unions and the general public. Working in partnership with Trade Unions/employee representatives and staff associations is an important part of ensuring fairness and promoting awareness of the policies, procedures and support mechanisms which a good employer will have in place[1].

DEFINING RAISING CONCERNS IN THE PUBLIC INTEREST

4. Raising a concern/s is defined as “raising a concern in the public interest is the action of telling someone in authority either internally or externally about wrongdoing, risk or malpractice” [2]. The wrongdoing is often related to financial mismanagement, such as misrepresenting earnings and false accounting, but can also have more immediate consequences such as those highlighted in the Mid Staffordshire Report (2013)[3].

[1] Raising Concerns at Work: Whistleblowing Guidance for Workers and Employers in Health & Social Care (NHS, 2014)
[2] NIAO Raising Concerns – A good practice guide for the N Ireland public sector (June 2020)
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

5. Staff can report things that are not right, are illegal or if anyone is neglecting their duties. This might include, for example, concerns around:
   - patient safety;
   - health and safety at work;
   - environmental damage; or
   - a criminal offence (e.g. fraud).

6. Raising concerns in the public interest can also be broadly defined as simply 'raising a concern'[5] in the public interest. People outside the organisation, including stakeholders, suppliers and service users, can also raise concerns through the HSC Complaints Procedure. However, raising a concern in the public interest is different from making a complaint or raising a grievance (as is outlined below at section 20). Persons raising concerns in the public interest can often act out of a feeling of fairness or ethics rather than a personal complaint. As Protect states, it is important to note that:

   "....*the person blowing the whistle is usually not directly, personally affected by the danger or illegality. Consequently, the whistleblower rarely has a personal interest in the outcome of any investigation into their concern – they are simply trying to alert others. For this reason, the whistleblower should not be expected to prove the malpractice. He or she is a messenger raising a concern so that others can address it*".[4]

WHY DOES RAISING CONCERNS IN THE PUBLIC INTEREST MATTER?

7. Staff and others are the eyes and ears of the organisation and those who are prepared to speak up about malpractice, risk, abuse or wrongdoing should be recognised as one of the most important sources of information for identifying and addressing concerns raised in the public interest[5].

[4] Where's whistleblowing now? 10 years of legal protection for whistleblowers, PCaW, March 2010
[5] Whistleblowing in the Public Sector: A good practice guide for workers and employers, published jointly in November 2014 by Audit Scotland, the National Audit Office, the Northern Ireland Audit Office and the Wales Audit Office, with the support of Public Concern at Work

8. It is important for individuals to feel safe and listened to when raising concerns. An open approach to raising concerns in the public interest promotes the Health and Social Care shared values and encourages employees and others to treat patients and service users with dignity, respect and compassion.

9. From the employer's point of view, there are good business reasons for listening to those who raise concerns, as it gives an opportunity to stop poor practice at an early stage before it becomes normalised and serious incidents take place.

10. The freedom to raise concerns without fear means that anyone who wishes to or is considering raising a concern has the confidence to go ahead and "do the right thing". It is part of encouraging staff to reflect on practice as a way of learning[1].

SCOPE

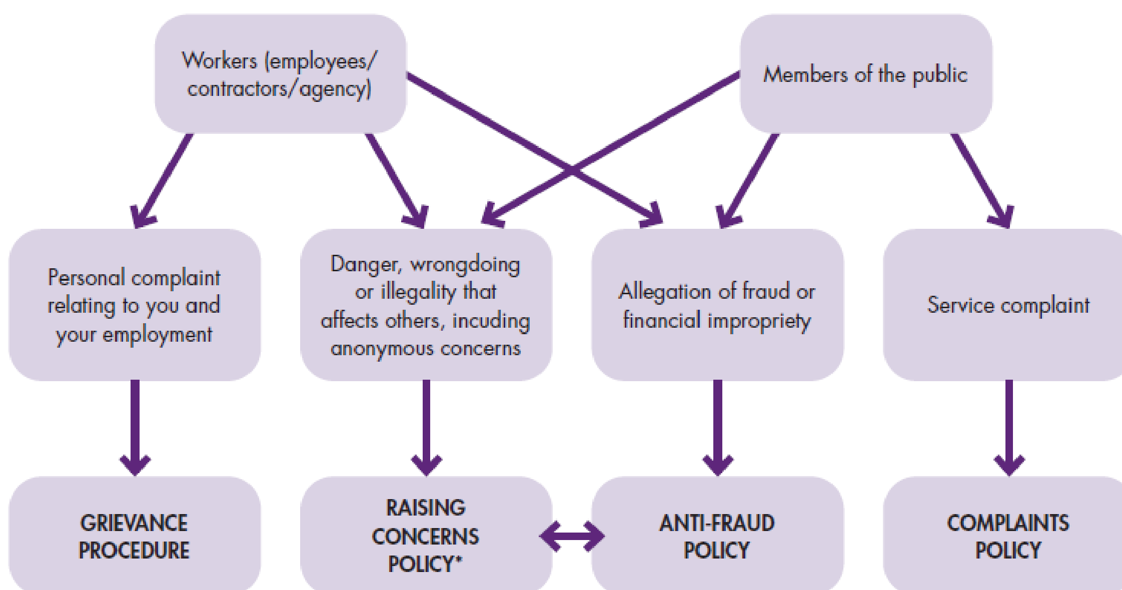
11. This Framework and Model Policy was developed in response to the recommendations arising from the Regulation and Quality Improvement Authority's (RQIA) Review of the Operation of Health and Social Care Whistleblowing Arrangements[6]. The Model Policy, to be adopted by all HSC organisations in Northern Ireland, is set out at **Appendix A**. HSC organisations may tailor the Model Policy to take account of their individual organisation's policies and procedures.

12. This Framework and Model Policy applies to **all staff** (employees, students, those on placements, volunteers, workers and others[7]) involved in the work of an HSC organisation.

13. The table below which is taken from the NIAO guidance explains how various complaints may be best taken forward by the organisation:

[6] Review of the Operation of Health and Social Care Whistleblowing Arrangements (RQIA, 2016)
[7] Definitions set out in Articles 3 (3) and 67K of the Employment Rights (Northern Ireland) Order 1996

Figure 1 summarises the types of issues that may be raised and the relevant policies which should apply:



14. The framework may not apply in every instance to patients and clients or members of the public who wish to complain or raise concerns about treatment and care provided by the HSC organisation or about issues relating to the provision of health and social care unless the concerns are in the public interest. Concerns relating to matters of care which are personal to an individual or a relative may be more appropriately dealt with under the organisation's **HSC Complaints Procedure**.

15. This Framework and Model Policy is for staff and others to raise issues where the interests of others or the organisation are at risk. If a member of staff is aggrieved about their personal position they must follow the local grievance procedure or policy for making a complaint about Bullying and/or Harassment.

14. All cases of suspected, attempted or actual fraud raised under this policy will be handled promptly in line with the organisation's Anti-Fraud Policy and/or **Fraud Response Plan.**

AIMS

16. The aim of this Framework and Model Policy is to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 (as amended) a member of staff is able to raise concerns when they believe that a person's health may be endangered or have concerns about failure, malpractice, misconduct or illegal practice without fear of detriment or victimisation.

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17. If a member of staff has honest and reasonable suspicions about issues of malpractice/wrongdoing in the public interest and raises these concerns through the channels outlined in the model policy, they will be protected from any disciplinary action and victimisation/less favourable treatment, (e.g. dismissal or any action short of dismissal such as being demoted or overlooked for promotion) simply because they have raised a concern under this policy.

18. This Framework and Model Policy aims to improve accountability and good governance within the organisation by assuring the workforce that it is safe to raise their concerns.

19. The benefits of encouraging staff and others to report concerns in the public interest include[1]:
    - Protection and enhancement of patient safety and wellbeing;
    - identifying wrongdoing as early as possible;
    - exposing weak or flawed processes and procedures which make the organisation vulnerable to loss, criticism or legal action;
    - ensuring critical information gets to the right people who can deal with the concerns;
    - avoiding financial loss and inefficiency;
    - maintaining a positive corporate reputation;
    - reducing the risks to the environment or the health and safety of employees or the wider community;
    - improving accountability; and

- deterring staff from engaging in improper conduct.

KEY PRINCIPLES & VALUES

Distinction between grievance & raising concerns in the public interest

20. Raising concerns in the public interest concerns generally relate to a risk, malpractice or wrongdoing that affects others, and may be something which adversely affects patients, the public, other staff or the organisation itself. A grievance differs from a raising a concern in the public interest as it is a personal complaint regarding an individual's own employment situation. A whistleblowing concern is where an individual raises information as a witness whereas a grievance is where the individual is a complainant. Grievances are addressed using the HSC Grievance Policy. On occasion a personal concern may also have wider implications in terms of others / the public and can therefore have both a grievance element and a Raising Concerns element.

Raising a concern openly, confidentially, or anonymously

21. In many cases, the best way to raise a concern in the public interest is to do so openly. Openness makes it easier for the organisation to assess the issue, work out how to investigate the matter and obtain further relevant information.

22. A worker raises a concern confidentially if they give their name on the condition that it is not revealed without their consent. If an organisation is asked not to disclose an individual's identity, it will not do so without the individual's consent unless required by law (for example, by the police). A worker raises a concern anonymously if they do not give their name at all. If this happens, it is best for the organisation to assess the anonymous information as best it can, to establish whether there is substance to the concern and whether it can be addressed. Clearly if no-one knows who provided the information, it is not possible to reassure or protect them and may hamper any investigation that may be required and to provide an outcome.

Claims found to have been made not in the public interest

23. There may be occasions when a concern is found to have not been made in the public interest. In such a case, and as set out in the model policy at Appendix A, the organisation cannot give the assurances and safeguards included in the policy. Such situations should be handled carefully. The starting point for any organisation is to look at the concern and examine whether there is any substance to it. Every concern should be treated as having been made genuinely and with a reasonable belief, unless it is subsequently found not to be. However, if it is found that the individual raised a concern that they know is untrue, disciplinary proceedings may be commenced against that individual.

Legal Framework

24. The Department of Environment has produced a Guide to Public Interest Disclosure Legislation public-interest-disclosure-guidance.pdf which provides a comprehensive guide to the relevant legislation.

HANDLING CONCERNS

25. To enable the effective operation of the raising concerns in the public interest policy, it is important to ensure that the policy empowers all staff and others, not just health and medical professionals, to raise a concern, and identifies who they can contact.

26. Legal protection is very important if staff are to be encouraged to raise a concern in the public interest about risk, wrongdoing or malpractice. It is vital that employers develop an open culture that recognises the potential for staff to make a valuable contribution to the running of public services, and to the protection of the public interest.

27. Managers must lead by example, by being clear to staff as to what sort of behaviour is unacceptable, and by role modelling the appropriate behaviours themselves. They should encourage staff to ask them what is appropriate if they are unsure before - not after - the event. If wrongdoing or a potential risk to patient safety is found, it should be taken seriously and dealt with immediately.

IMPLEMENTING LOCAL POLICY

28. It is important that all HSC organisations are committed to the principles set out in their raising concerns policies and encourage staff and others to speak up about malpractice, risk, abuse or wrongdoing within their organisation. To achieve this, it is necessary to ensure buy-in and leadership from management, and Trade Union engagement.

29. Within each organisation, an appropriate senior manager should be appointed to take responsibility for ensuring implementation of the raising concerns in the public interest policy. HSC organisations should also consider appointing an appropriate number of advisors/advocates to signpost and provide support to those wishing to raise a concern in the public interest. In addition, it is essential that the Board as a whole maintain oversight of the raising concerns policy and each organisation should appoint a Non-Executive Director (NED) to have specific responsibility for oversight of the culture of raising concerns within their organisation.

30. As an employer, HSC organisations must take all concerns raised seriously. However, it may not be necessary to carry out a formal investigation in each case. Employers should consider a range of possibilities proportionate to the risk and complexity of the issues raised which should include:
    - explaining the context of an issue to the person raising a concern may be enough to alleviate their concerns
    - minor concerns might be dealt with straightaway by line management by for example taking appropriate remedial action

- a review by internal audit as part of planned audit work might be sufficient to address the issue e.g. through a change to the control environment
- there may be a role for external audit in addressing the concerns raised and either providing assurance or recommending changes to working practices
- there may be a clear need for a formal investigation to establish the facts and in some cases make recommendations.

31. Having considered the options it is important that employers clearly document the rationale for the way forward. The HSC organisation's local policy should make it clear whose responsibility it is to decide on the approach to be adopted.

32. If necessary, the HSC organisation can also seek advice and guidance from the relevant prescribed person such as a regulator.

33. When an organisation is updating or changing their policy it is important to ensure all staff are aware of any changes or updates, and this can be achieved in a number of ways: through hard copy correspondence with staff, communication by email and/or via organisation's intranet sites, through team briefings and inductions, or the message appearing on payslips. It is also important to ensure that the policies are accessible.

BRIEFING & TRAINING

34. Many public interest concerns will be raised openly with line managers as part of normal day-to-day practice and this is strongly encouraged. Good raising concerns arrangements should do nothing to undermine this. It is important that this is made clear to both staff and managers.

35. All managers and raising concerns advocates' contacts should be briefed on:

- the value and importance of an open, accountable, just and learning workplace;

- how to handle concerns fairly, professionally and responsively;
- how to protect staff who raise a concern in the public interest and where staff can get help or refer a concern;
- how to manage expectations of confidentiality;
- the importance of an alternative to line management if the usual channels of communication are unavailable; and
- how to brief their staff on arrangements for raising concerns in the public interest.

36. Raising Concerns Advocates and Senior Managers who are given a specific role in the raising concerns arrangements should receive training in the operation of their policy for raising concerns.

AUDIT, REVIEW & REFRESH

37. A well-run organisation must review its raising concerns arrangements a minimum of every three years through formal governance arrangements to ensure they work effectively and that staff have confidence in them. The following points can assure the organisation that the arrangements meet best practice. Monitoring the arrangements in line with this checklist will also help the organisation demonstrate to regulators that their arrangements are working:

- arrange regular feedback sessions to evaluate progress and collect data on the nature and number of concerns raised in the public interest;
- check the procedures used are adequate to track the actions taken in relation to concerns raised and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by raising concerns in the public interest. Is there evidence of constructive and timely feedback?
- have there been any difficulties with confidentiality?
- have any events come to the organisation's attention that might indicate that a staff member has not been fairly treated as a result of raising a concern in the public interest?

- look at significant adverse incidents/incident management systems or regulatory intervention - could the issues have been picked up or resolved earlier? If so, why weren't they?
- compare and correlate data with information from other risk management systems;
- find out what is happening on the ground - organisations will include a question about awareness and trust in arrangements for raising concerns in the public interest in future HSC staff surveys;
- organisations should seek the views of trade unions/professional organisations, as employees might have commented on the raising concerns in the public interest arrangements or sought their assistance on raising or pursuing a raising concerns in the public interest concern;
- organisations could also consider other sources of information, including information from exit interviews, claims brought under the Order or other legal claims;
- key findings from a review or surveys should be communicated to staff. This will demonstrate that the organisation listens and is willing to learn and act on how its own arrangements are working in practice;
- refresh raising concerns in the public interest arrangements regularly. Regular communication to staff about revised arrangements is also recommended;
- although volunteers are not covered by the Order, the application of this Framework and Model Policy should be considered in the handling of their concerns (however, there are some elements of the policy which will not apply to volunteers such as the legal right to take a case to an Industrial Tribunal); and
- think about reporting good news - success stories encourage and reassure everybody.

REPORTING & MONITORING

38. Concerns raised in the public interest by staff and others are an important source of information for HSC organisations. It is important that they capture key aspects so that the value of their raising concerns in the public interest arrangements can be determined and lessons learned where appropriate.

39. In addition to individual case files, HSC organisations should maintain a central register of all formal concerns raised in the public interest, in a readily accessible format. Any system for recording concerns should be proportionate, secure and accessible by the minimum necessary number of staff.

40. An analysis of concerns raised should be reported regularly to senior management and the HSC organisation's Audit Committee. These will help inform those charged with governance that arrangements in place for staff to raise concerns in the public interest are operating satisfactorily or will highlight improvements that may be required. HSC organisations should consider reporting on the effectiveness of their raising concerns arrangements in their annual report.

APPENDIX A: MODEL POLICY ON RAISING CONCERNS IN THE PUBLIC INTEREST

1. Introduction

All of us at one time or another may have concerns about what is happening at work. The [*name of HSC organisation*] wants you to feel able to raise your concerns in the public interest with your managers at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when a concern raised in the public interest appears to be potentially serious because it is about a possible danger, professional misconduct or financial malpractice, illegality or wrong doing that might affect patients, colleagues, or *[name of HSC organisation]* itself, it can be difficult to know what to do.

The [*name of HSC organisation*] recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns raised in the public interest which are **remain unresolved, require help to get resolved or are about serious underlying concerns.**

Raising concerns in the public interest refers to staff reporting suspected wrongdoing at work, for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence, such as, fraud.

You may be worried about raising such issues in the public interest and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Rather than wait for proof, raise the matter when it is still a concern. If something is troubling you which you think we should know about or look into, please let us know. The [*name of HSC organisation*] has implemented these raising concerns arrangements for you to raise any concern in the public interest where the interests of others or the organisation itself are affected or are at risk.

2. Aims and Objectives

[Name of HSC organisation] is committed to running the organisation in the best way possible. The aim of this policy is to promote a culture of openness, transparency and learning in line with the HSC shared values which at the same time:

- reassures you that it is safe and acceptable to speak up;
- upholds patient confidentiality;
- contributes towards improving services provided by the [*name of HSC organisation*];
- assists in the prevention of fraud and mismanagement;
- demonstrates to all staff and the public that the [*name of HSC organisation*] is ensuring its affairs are carried out ethically, honestly and to high standards;
- provides an effective and confidential process by which you can raise concerns in the public interest so that patients, clients and the public can be safeguarded.

The *[Name of HSC organisation]* roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. Scope

The [*name of HSC organisation*] recognises that existing policies and procedures (Disciplinary, Grievance, Conflict, Bullying and Harassment, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate for concerns raised in the public interest.

This policy provides a procedure for raising concerns in the public interest where the interests of others or of the organisation itself are at risk.

It applies to the following groups:

- staff of the [*name of HSC organisation*], including permanent, temporary and bank staff;
- staff in training/placements working within the [*name of HSC organisation*];
- independent contractors engaged to provide services;
- volunteers;
- agency staff;
- Members of the public.

Examples may include:

- malpractice or ill treatment of a patient or client by a member of staff;
- where a potential criminal offence has been committed, is being committed or is likely to be committed;
- suspected theft or fraud;
- breach of Standing Financial Instructions;
- disregard for legislation, particularly in relation to Health and Safety at Work;
- the environment has been, or is likely to be, damaged;
- Failing to declare a conflict of interest;
- a miscarriage of justice has occurred, is occurring, or is likely to occur;
- showing undue favour over a contractual matter or to a job applicant;
- research misconduct; or
- information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think is in the public interest that *[name of HSC organisation]* should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you personally have been treated, you should follow the [*name of the HSC organisation's*] local grievance procedure or Conflict, Bullying and Harassment policy for making a complaint about Bullying and/or Harassment. This policy complements professional and ethical rules, guidelines and codes of conduct.

It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised. (However such issues can be raised under this process if no other more appropriate avenue is apparent).

4. Suspected Fraud

If your concern is about possible fraud or bribery [*name of HSC organisation*] has a number of avenues available to report your concern. These are included in more detail in the [*name of HSC organisation's*] Fraud Policy, Fraud Response Plan and Anti-Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager but where you do not feel this is not appropriate the following officers may be contacted:

- Senior Manager
- Head of Department
- Director of Finance
- Fraud Liaison Officer (FLO)

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by BSO Counter fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The [*name of HSC organisation's*] Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the [*name of HSC organisation's*] or under its control. The [*name of HSC organisation*] expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5 *[Name of HSC organisation]* commitment to you

5.1 Your safety

The [*name of HSC organisation*], Board, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a concern in the public interest under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The [*name of HSC organisation*] will not tolerate the harassment or victimisation of anyone who raises a concern in the public interest.

The [*name of HSC organisation*] expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a concern in the public interest or victimises them, this will be viewed as a disciplinary matter.

Provided you raise a concern in the public interest and with a reasonable belief in its truth, it does not matter if turns out that you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. If staff raise a matter they know to be untrue, protection under the law cannot be guaranteed and the [*name of HSC organisation*] reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, the [*name of HSC organisation*] hopes that you will raise concerns openly in the public interest. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in [*name of Directorate and contact details*].

Where possible, the [*name of HSC organisation*] is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. As far as possible, confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. Further, without additional evidence, it may be difficult to investigate such complaints properly in order to establish the facts. So, while we will consider anonymous reports in a similar manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously.

6. Raising a concern

If you are unsure about raising a concern in the public interest, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern in the public interest, only a reasonable belief that an act of wrongdoing has occurred or that there has been a deliberate attempt to cover up a wrongdoing. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.
If you remain unsure about raising a concern in the public interest you can get independent advice from Protect (see contact details under Independent Advice).

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager (or lead clinician or tutor). Where you do not think it is appropriate or it has failed to resolve the matters satisfactorily you can contact one of the following people:

- the raising concerns advocate [insert details]
- the HR or Governance Team (whichever is appropriate) [insert details]
- A more Senior Manager

If you still remain concerned after this, you can contact:

- the [name] Director with responsibility for raising concerns in the public interest [insert details] or

All these people have been trained in receiving and identifying how best to respond to concerns in the public interest and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see paragraph 7 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the concern raised should progress.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your trade union/professional organisation.

Advice is also available through the independent charity (Protect) on 020 3117 2520. www.protect-advice.org.uk

6.3 How should I raise my concern?

You can raise your concerns in the public interest with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. Raising a concern externally

The [*name of HSC organisation*] hopes this policy reassures you of its commitment to have concerns raised in the public interest under the policy taken seriously and where appropriate and/or necessary fully investigated, and to protect an individual who raises such concerns in the public interest.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, the [*name of HSC organisation*] would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, the [*name of HSC organisation*] recognises that there may be circumstances where you can raise a concern in the public interest with an outside body as specified in following schedule to The Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2014 at http://www.legislation.gov.uk/nisr/2014/48/contents/made for a full list of contacts.

Disclosure to these organisations/persons will be protected provided you honestly and reasonably believe the information and associated allegations are substantially true.

We would wish you to raise a matter with the external agencies listed above than not at all. Protect (or your union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. The media

You may consider going to the media in respect of your concerns if you feel the [*name of HSC organisation*] has not properly addressed them. You should carefully consider any information you choose to put into the public domain to ensure that

patient/client confidentiality is maintained at all times. The [*name of HSC organisation*] reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the [insert name of Department] on behalf of the [*name of HSC organisation*]. Staff approached by the media should direct the media to this department in the first instance.

9. Conclusion

While we cannot always guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and thoroughly. By using these raising concerns in the public interest arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (as amended) (the Order) which provides employment protection for raising concerns in the public interest.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that the matters specified in the concern raised occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to the [*name of HSC organisation*] listed in the Order.

10. Appendices

Appendix A – Roles and Responsibilities
Appendix B – Procedure
Appendix C – Advice for Managers

11. Equality, Human Rights & DDA

[The [*name of HSC organisation to confirm*] This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the [*name of HSC organisation*] to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories.

The policy has been **screened out** without mitigation or an alternative policy proposed to be adopted.]

12. Personal & Public Involvement (PPI)/Consultation Process

[*name of HSC organisation to confirm*]

13. Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

14. Sources of advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

15. Policy Sign Off

Lead Policy Author	Date
Director of HR	Date

APPENDIX A ROLES AND RESPONSIBILITIES

The role of the [Insert name of Trust] Board (including the designated Non-Executive director (NED))

- To have responsibility for oversight of the culture of raising concerns within their organisation in accordance with the HSC Board Member Handbook (sections 4.12) [8].

The [name of HSC organisation]

- To listen to our staff, learn lessons and strive to improve patient care;
- To ensure that this policy enables concerns raised in the public interest to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise concerns in the public interest are not penalised for doing so unless other circumstances come to light which require this, e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue.
- To share learning, as appropriate, via our shared learning procedures

The Responsible/designated Senior Manager/s

- To take responsibility for ensuring the implementation of the raising concerns in the public interest arrangements.

Managers

- To take any concerns raised with them in the public interest seriously and consider them fully and fairly and respond appropriately taking any necessary and appropriate action
- To recognise that raising a concern in the public interest can be a difficult experience for some staff and to treat the matter in a sensitive manner if required
- To seek advice from other professionals within the [*name of HSC organisation*] where appropriate
- To invoke the formal procedure and ensure [*name of Directorate*] is informed, if the issue is appropriate

[8] https://www.health-ni.gov.uk/publications/hsc-board-member-handbook

- To ensure feedback/ learning at individual, team and organisational level on concerns raised in the public interest and how they were resolved

Raising concerns advocate

- To ensure that any safety issue about which a concern has been raised is dealt in accordance with the procedures and promptly and escalated appropriately through all management levels
- To intervene and if appropriate escalate, if there are any indications that the person who raised a concern in the public interest is suffering any recriminations
- To work with managers and HR to address the culture in an organisation and tackle any obstacles to raising concerns in the public interest

All Members of Staff

- To recognise that it is your duty to draw to the [*name of HSC organisation*] attention any matter of concern in the public interest
- To adhere to the procedures set out in this policy
- Where possible, to maintain the duty of confidentiality to patients and the [*name of HSC organisation*] and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Nursing & Midwifery Council or the General Medical / Dental Council.

Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Nursing & Midwifery Council, the General Medical Council, Health Professional Council and the Social Care Council for Northern Ireland.

APPENDIX B EXAMPLE PROCEDURE FOR RAISING A CONCERN

Note that if a concern raised in the public interest is adjudged to be serious in nature the receiving manager should escalate that concern to a senior manager for investigation. This essentially allows for a manager to escalate a concern to the formal stage where it will be formally recorded on the Trust register.

Informal - Manager

If you have an honest and reasonable belief that a concern which is in the public interest about malpractice, risk, abuse or wrongdoing has occurred, is occurring, or is likely to occur, then the matter should be raised informally in the first instance with your Line Manager (lead clinician or tutor). This may be done verbally or in writing.

You are entitled to support from a trade union/ fellow worker or companion to assist you in raising your concern in the public interest.

Informal – Alternative to Manager

If you feel unable to raise the matter with your Line Manager (lead clinician or tutor), for whatever reason, please raise the matter with our raising concerns advocate or a more senior manager from the organisation.

[Insert name of raising concerns advocate/s]

[contact details]

This person has been given special responsibility and training in dealing with concerns raised in the public interest. They will:

- (where possible) treat your concern confidentially unless otherwise agreed;
- ensure you receive timely advice on how best to progress your concerns;
- escalate to the appropriate authority any indications that you are being subjected to detriment for raising your concern in the public interest;
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with;

- ensure you have access to personal support through for example your employee assistance programme (e.g. Inspire etc.) since raising your concern in the public interest may be stressful.

Whilst it would be the preference of the (insert name of organisation) for you to raise the matter openly, if you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Formal

If these channels have been followed and you still have concerns or your concerns remain unresolved, or if you feel that the matter is so serious that you cannot discuss it with any of the above through the informal process, please contact:
[name]

[contact]

Screening

The [insert name of the Trust] will undertake a screening process for any formally raised concern. This process will determine the most appropriate route/s and process/es for all or parts of your concern.

Prescribed Bodies (or media)

You can raise your concerns in the public interest formally with the prescribed external bodies listed at paragraph 7 or to the media – note that you don't have to exhaust either of the above stages if you decide to go straight to the prescribed bodies or media – see also at a glance section above:

- If you choose to bypass the routes available for you to make a disclosure (directly to the Trust or via outside organisations referred to in the legislation) and instead approach the media with your concerns, it is likely you will lose your right to protection under Whistleblowing legislation. The exception to this is a case where the wrongdoing is exceptionally serious and where you reasonably believe that the Trust will subject you to 'detriment' or conceal/destroy evidence if you were to raise your concerns via the routes available to you.

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, or if the matters raised are serious in nature we will carry out a proportionate investigation – using someone suitably independent and trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation e.g. a Serious Adverse Incident (SAI) investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of the [name of HSC organisation] to follow the process as above.

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure it will not be appropriate to categorise it under the [*name of HSC organisation*] Raising Concerns Policy.

Communicating with you

We welcome the raising of concerns in the public interest and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. In the event that an investigation is required, we will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. In so far as it is appropriate, we will provide feedback to the person who raised the concern.

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant professional Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

Board oversight

The [*name of HSC organisation*] board and the Department of Health will be given high level information about all concerns raised in the public interest by our staff and others through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff and others raising concerns and want you to feel free to speak up. The Chair has

nominated a non-executive director (NED) with responsibility for the oversight of the organisation's culture of raising concerns.

The [Insert name of the Trust] NED responsible for Raising Concern is [INSERT NAME].

Review & Reporting

We will provide regular reports to senior management and to our HSC's Designated Committee within the Assurance Framework on our raising concerns in the public interest caseload and an annual return to the Department of Health setting out the actions and outcomes.

This policy has been reviewed against the NI Audit Office – Raising Concerns – A good practice guide for Northern Ireland Public Sector.

APPENDIX C - ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Managers should maintain an understanding of the process for raising a concern in the public interest;
2. Seek advice from the Trust lead on raising concerns if in doubt at any stage;
3. Thank the staff member for raising the concern, even if they may appear to be mistaken;
4. If appropriate refer the member of staff to other independent sources of advice and guidance on raising concerns in the public interest;
5. Respect and heed legitimate staff concerns about their own position or career;
6. Manage expectations and respect promises of confidentiality;
7. Discuss reasonable timeframes for feedback with the member of staff;
8. Remember there are different perspectives to every story;
9. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing;
10. The Trust should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise at any time during the investigation the investigator must alert the manager as quickly as possible. (Note: Any such conflict must be considered, and acted on, by the manager);
11. Managers should bear in mind that they may have to explain how they have handled the concern;
12. Feed back to the person who raised the concern and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe any rights or duties which may be owed to other parties;

13. Consider reporting to the board and/or an appropriate regulator (if appropriate) the outcome of any concern raised in the public interest where malpractice or a serious safety risk was identified and addressed; and
14. Record-keeping - it is prudent to keep a record of any concerns raised formally with those designated under the policy, and these records should be anonymous where necessary. Managers should record any concerns raised informally and document action taken to resolve matters.

Appendix D Raising Concerns in the Public Interest & Whistleblowing Process