NHS Employers response to the Department of Health consultation on the implementation of recommendations, principles and actions set out in the Freedom to Speak Up report

NHS Employers

The NHS Employers organisation represents views from organisations across the NHS in England on a range of workforce issues, supporting employers to put patients first. Our role is to help employers understand and contribute to changes affecting them. This includes providing general advice and guidance on good practice, as well as representing NHS organisations to policy makers. We work with the HR community and the whole range of Board level members to ensure we arrive at a position based on the views of employers. Our work spans the whole remit of workforce issues and has both an overview and responsibility for the delivery of a number of workforce functions including pay, reward, employment practice, regulation, and planning.

We also have a range of programmes in place to enhance and support staff experience including staff engagement, organisational development, values based recruitment, health, work and well-being, equality and diversity and over the last few months have developed a substantial resource with partners in Skills for Care to support managers with people performance management.

In relation to raising concerns we have a programme of work that is focused on supporting the sharing of learning among organisations and we see this as being an integral part of taking forward the recommendations in the Freedom to Speak Up review (FTSU). Our campaign ‘Draw the line’ resources for employers were published in February 2015. It was followed by an event for 80 NHS leaders in April 2015 on both the practical issues in taking forward the actions and sharing examples of positive progress in safety and learning culture through using of values and engagement as the core principle for affecting change.

We are committed to working across the system and with employers to highlight how collectively these programmes can lead to a positive organisational culture where concerns are raised and handled effectively as a normal part of employment practice.

Our response

Our response to this consultation has been informed through engaging with employers - gathering intelligence prior to and during the Freedom to Speak Up review and the result of specific activity we have undertaken since the publication of the report, which includes the launch of our ‘Draw the line: together we can make a difference’ campaign in February 2015 and the event in April 2015.

We have provided some general comments and then comments on the main questions posed in the consultation.

General comments

- NHS leaders are committed to making improvements in their organisations around the raising and handling of concerns.
- Much work has been undertaken in recent years around systems, policies, process and organisational development and this needs to be supported to continue.
- There appears to be a correlation between organisations who score well on staff engagement scores in the NHS Staff Survey and those who score better on the questions relating to staff feeling safe to raise concerns and having confidence that action will happen as a result.
- We know that altering policies alone will not build the trust, confidence and competence amongst individuals and teams that is needed to see a significant shift in peoples' perceptions about feeling safe to raise a concern. We need to keep progressing with all of the work around staff experience (particularly staff engagement) if we are to see values driving behaviour change in all aspects of employment and practice, recognising that this is about a way of working, not an initiative, and change will take time.
- We know engaging with staff at a local level is the way in which positive change will be realised – the same principle applies to national bodies working together with local employers as they work on implementing recommendations in the report. We strongly advocate working with employers to develop and agree a way forward for some of the recommendations.
- Where multiple organisations are cited to take action, it may be appropriate to develop some agreed outcomes and guidance to provide the clarity that will be needed for it to be effective. NHS Employers would be happy to work with stakeholders to contribute to this piece of work.
- Many of the actions focus on the raising of concerns. An equal focus needs to be placed on effective handling. We know that perceptions and confidence are affected by how well people have seen or heard about other cases being handled.
- We know that most people know how to raise concerns and that the area for focus is on building confidence so that everyone feels safe to raise a concern and that they have confidence action will be taken.

Section 1

Comments on taking forward the twenty principles and associated actions

There is general support for the principles identified in the report and many of the actions. The task now is for local employers and national bodies to identify approaches that are effective and proportionate. We need a collective approach around how the actions are implemented as opposed to what the action is. In reviewing the 38 actions we have looked at:

- the importance of being able to build on activity already in train locally
- when it would be helpful to have guidance to mitigate against repetition of effort and ensure clarity on objective and outcome between providers and regulators
- the actions as a package and not individual items
- proportionality and adding value through additional administration.

Principle 1: Measuring culture is not easy and there have been a number of attempts to develop tools and approaches. In taking forward this action in an effective and consistent way, it may be helpful to identify a small set of measures or the types of data and intelligence to triangulate to help providers monitor progress and the regulators gain assurance.

Principle 2: In light of the FTSU review we know many organisations have reviewed their policy and procedure. There is also recent national guidance on raising (whistleblowing) concerns and it would be helpful to clarify whether this should continue to be the first point of referral by employers or if a new policy is being developed.

Principle 3: In taking a zero tolerance to bullying and embedding values based leadership and practice, it is for local employers to take forward action that creates a culture free of bullying. Sharing of good practice would be helpful.

Principle 4: We have many examples of how NHS leaders use methods to openly discuss issues with staff and staff have access to senior leaders – in all cases those leaders talk of and demonstrate the importance of staff engagement and values based leadership. Encouraging the spread of values driven behaviour will be important in delivering on many of the actions in the report and help ensure the messages staff hear and the behaviour they see are consistent, and consistent from all levels of management. Examples and case studies are available via our website or please contact us directly if you wish to discuss this further.

Principle 5: We think it is for local employers to work with their own staff on how they wish to celebrate what they are doing in a way which fits with other local recognition activity. We know the positive impact praise and recognition can have on staff motivation. This can be achieved using existing resources at a local level.

Principle 6: Reflective practice is an integral part of revalidation for registered healthcare professionals. We know that some organisations organise learning sessions to discuss incidents, encourage multi-disciplinary team meetings to reflect

on cases or use the Schwartz round methodology. There is variation across the country and we believe that this can work effectively as long as we are clear on the purpose and outcome and that all staff have the opportunity contribute in reflective discussions and take forward any learning into future practice.

The biggest challenge we see in implementing this action will not be influencing staff and managers that it is the right thing to do, but ensuring that capacity (time) is consistently made available and that it is prioritised above what will also seem like important actions or tasks. Complementary and consistent messaging from professional regulators in their documentation will be helpful to reinforce the professional duty to encourage reflective practice as individuals and as teams.

Principle 7: We fully agree that informal approaches should be encouraged to resolve issues and that if a concern is raised formally then a mechanism for feedback to the individual who has raised the concern should be in place. On this latter point we often receive comments about the challenges of managing confidentiality alongside a need to open and uncertainty around sharing information in cases which become very complex. We would be supportive of the training package (covered in principle 10), including scenarios and examples to support the effective and prompt delivery of feedback.

Principle 8: With small organisations or in a particular circumstance it may be appropriate to seek external input to lead investigations, however it does not need to be the default position. Using external investigators may also have a cost to the system which would need factoring in.

Investigators need to be trained, have the time and access to information when needed and be seen as credible by staff. We have seen a model where an employer has a team of skilled and trained individuals drawn from across the organisation who will be allocated to investigate and review cases that have escalated to a formal concern. They also act as an informal group of peer support for each other. This model works well for this organisation and in large NHS organisations, may be a suitable approach others wish to adopt.

Developing local networks for peer support will be important. We do not see it will be feasible for the INO role to provide the day to day support and informal learning that will be gained by local teams building experience and competence in managing complex investigations.

Principle 9: There are many independent contractors who can provide mediation and reconciliation if required. In light of the recent focus on procurement in the NHS it may be prudent to consider whether there should be a pool of appropriately trained individuals who can be accessed when needed or a national framework agreement for companies offering mediation.

Principle 10: We are pleased to see this has a focus on both raising concerns and receiving/acting on them. Training can be delivered in different ways. As we have started to discuss what might be needed by different groups we have concluded that a curriculum that all staff work through is not necessary.

We have separated this action into two distinct parts: first that each organisation has training or awareness raising material around their local process and what a person

can expect to happen if/when they raise concern. Templates exist and could be reviewed to ensure current fit for purpose and made publicised as available for local employers to use if they don't have one already. Short examples provided of how this could be rolled out to ensure costs do not escalate unnecessarily may be helpful and relatively easy to produce. We think awareness raising will be sufficient as the feedback most staff give is that they know how to raise a concern.

The second piece is where we think it would be more appropriate to invest resource to develop and deliver a training package for all line managers. If we can support managers in this area, alongside the right leadership approach, we are likely to see perceptions and confidence levels in staff improve.

If we start with this as the desired outcome, the training could cover areas such as the managers' role in encouraging an open culture in their teams, helping them act on concerns early and escalating promptly where necessary. Cases are often complex and so having the ability to work through complex scenarios and discuss options with colleagues would be useful. Increasing line manager confidence and capability around handling concerns has the potential to make a significant difference to staff and patients.

We have worked on the assumption that the training package will be developed once, nationally, and it will be for local employers to run the sessions. It will be beneficial to develop the training material with employer involvement (NHS leaders and operational managers) to ensure that it achieves the desired objective. There are some organisations who have specific training for managers in handling concerns, many more provide training in 'having difficult/fundamental conversations' where the core skills may be complementary but the majority have suggested it would be helpful to develop a national package for local use.

From previous experience with this type of mass training roll-out, a team of trainers locally would need to be trained and dedicate their time to delivery of sessions to supervisors and managers working in all areas, on all shift patterns and at all levels of management. We therefore suggest a phased approach to roll-out, enabling employers to prioritise certain areas or grades of staff, dependent on their local needs.

In looking at the direct staffing costs of delivering training in each organisation we have looked at other models used: for example, if an organisation has 2000 staff who need training they could deliver 100 sessions to 20 managers over the course of six or 9 months.

This would be a significant undertaking with a staff cost of approximately £68,000 per organisation for x 2 AfC Band 7 trainers (mid-point of scale).

Larger organisations may need to phase their training over a 12 month period at a cost of approximately £90,000 per organisation.

It would be advisable to ensure training can continue for new recruits and so building this capacity into training functions for subsequent years would also be necessary.

There are obviously costs to lost clinical/work time which are a one-off and if the training is fit for purpose we would expect the return on investment in more effective leadership, management and handling of cases going forward.

Principle 11: We have covered the local guardian role in more detail in the following section. This is the one area of this principle which we see potentially requiring additional funding to be found on a recurrent basis. The other roles listed in the FTSU report allocate specific duties to individuals already in post.

We know most organisations have nominated executive and non-executive directors who are named as contact points in a local policy – much of the feedback has been that little contact is made with these individuals.

In describing the various contact points in a new approach to handling concerns it will be important to be clear if there are differences in what the individual or for example helpline will do – advice vs receive the concern and ensure it is investigated. This is important to manage expectations and confidence in the process.

Principle 12: We are not sighted on any discussions within the national bodies around creating an alternative employment scheme. Work needs to progress at pace to provide confidence to individuals that the national bodies are committed to working differently to support cultural change.

Principle 13: This principle and actions have the ability to become very administration heavy. Although we fully support transparency, these actions could drive duplication of reporting. Reflecting on principle 16 (national bodies working together to be clear on roles and responsibilities) and principle 1 (measuring and monitoring safety culture) we suggest that work is undertaken with providers to be clear what should be measured and agree a mechanism for publishing once in a report that can be viewed by either NLRS, INO, TDA, Monitor, CQC or local commissioners.

Analysis of the reports and published sharing of learning by a national lead (INO or NLRS) would be very welcome.

On settlement agreements the advice in the report resonates with what is within the NHS Employers guidance published in 2013/14. In terms of effective and proportionate roll-out of action 13.3 (d) we think this adds another layer into the process. As TDA/Monitor are required under HMT 'Managing Public Money' to receive applications from employers, we suggest they do not delegate some of this duty to another body in what is already a lengthy and complicated process. We suggest that if the regulator has concerns about the suitability of a confidentiality clause or language used in documentation, timely advice is sought from the INO.

Principle 14: To achieve the overall objective in this principle we draw on the importance of values and a behaviour framework which underpins these values. From our experience in leading the values based recruitment with employers in 2014-15 we have found that organisations who focused on embedding values into all employment processes and have a values based approach to leadership have seen progress in the confidence of staff to raise concerns. This is continual work and not an initiative, however the provision of some practical help on how to do this and where to start has been a common request from many organisations.

Principle 15: Employers would welcome the opportunity to understand how the national bodies are planning to create the INO role and function – and particularly

would be keen to ensure that there is clarity around the remit and its interface with the proposed local guardian role and other functions of CQC.

Principle 16: A clear and co-ordinated approach between regulators and national bodies would be welcomed by all and has the ability to drive efficiencies in the system, although not cash releasing, working together more effectively must be a primary objective.

Principle 17: If CQC are to review 'how' cases are handled as part of their assessment process it would be helpful to use this this intelligence to facilitate the sharing of good practice – whether this is though the INO to local guardians or directly. Reflecting back on the role of the new INO, it would not be cost effective to have the CQC and the INO looking at how cases are handled and re-state the importance of clear roles, remit and working relationships if this is to work effectively for everyone involved.

Principle 18: This is welcomed and supported.

Principle 19: We have not engaged with GP practices as part of this work (they fall outside of our remit) but for small provider organisations such as GP practices, we suggest they also have the opportunity to benefit through sharing of learning and training opportunities.

Principle 20: Ensuring the legal framework is fit for purpose is important however we believe that the priority for action nationally needs to be on how the national bodies are going to work differently, together and take forward the work as a result of the review to create guidance, templates, training material and share learning.

Section 2

The local 'Freedom to Speak Up' Guardian role

Clarity needed: This consultation has created some confusion among organisations. It appears that providers were tasked to move forward with the actions relating to them including creating a local guardian function in a way which fitted with their local circumstances and aligned to work they had already started in this area.

The publication of this consultation and its focus on questions about a standard title and training for the local guardian have led to a perception that a uniform approach will be expected and we know this has halted work rather than progress and have to unpick it later.

We firmly support the rationale within the FTSU report for creating named contacts who can advise, support and have the tenacity to challenge and push to get a fair resolution.

We also agree with the report which stated it should be for local employers to determine a model that works for them. We know from past experience that a national top-down approach is not always effective – however we can work collectively to be clear on objectives and outcomes and this will enable a decision based on form following function.

If we can be clear on outcomes and measures it also become easier to measure improvement in a more sophisticated way than for example counting the number of guardian roles.

We would also welcome clarity between the description of the local guardian in the consultation paper and what was suggested in the FTSU report. It is essential that managers in teams are equipped to encourage and deal with concerns raised, escalating to a formal process if necessary. We do not envisage one person in the organisation taking on all the listed responsibilities and would not recommend this as a model to achieve sustainability and a change of culture.

Possible approach: We suggest starting with working with a range of individuals including NHS leaders to define the overall expected outcomes.

Retaining options around whether the local guardian is a single role or a function provides the opportunity to harness what organisations have done around staff experience, deliver an open reporting culture and build a sustainable model for the organisation going forward.

This will help formulate how individual employers can take this forward and enable them to work with staff and staff-side locally to build a system which delivers improvements against the defined outcomes.

We know some organisations have successfully embedded local guardian roles with an individual occupying a specific post. There is clearly and rightly interest from all parts of the system to replicate and build on their success. We also know there are differences in what the current post-holders concerns about how this will succeed if it is mandated to be replicated as a standard format in every NHS organisation – we want to ensure that these concerns are flagged for discussion at this stage so they can be considered as the developments move to the next stage.

For those organisations looking at developing a local guardian role as an additional post, there are a mixture of views about whether the post-holder should be clinically trained. Although not essential in terms of competence, some have cited that it may help with credibility amongst peers, in the first instance.

Examples have been cited as a 0.5 WTE person who is an existing member of staff, who does not handle or investigate concerns but is someone who can be approached by all staff for advice or to raise a concern – if the latter occurs this would be referred back to the local unit for handling effectively if possible or escalated if necessary. The ‘guardian’ would continue to check back and ensure progress is being made, providing advice or reporting to the chief executive if they had concerns with any action or inaction.

If an additional post is created, it will need resourcing. Any efficiency savings made as a result of better handling of cases are likely not to be cash releasing but clearly will improve staff and patient experience. If the role is evaluated at, for example, Agenda for Change Band 7, a 0.5 WTE would require approximately £25,000 of investment to cover staffing costs per organisation.

Central to success - the local guardian (in whatever form this function takes) should:

- Support individuals with concerns to raise them with confidence, in their organisation, in a timely and appropriate way, providing information and signposting to support packages.
- Support managers in encouraging open conversations, receiving and dealing with concerns.
- Has the ability to challenge, be seen as impartial
- Work as part of team of individuals who are collectively working together to improve systems, processes and how cases are handled.
- Have a direct reporting arrangement in the employing organisation to the Chief Executive or equivalent (not the INO).
- Ensure clarity of the link and relationship between the local guardian function and the INO – we see a particular benefit here in providing a mechanism to share practical learning that may inform further iterations of the training programme, support professional development and provide a safe space to seek advice if needed.

Job title: We can see the many advantages of creating a standard job title and some organisations have stated that they see this as a helpful approach – the consultation does assume that the local guardian is a single person in every organisation. As stated above, we would prefer to agree outcomes, purpose, remit and potential deliverables and then agree the form or forms this could take.

It would be possible to use standard terminology to describe the function in every organisation. We know the words 'Freedom to Speak Up' resonate in many organisations and they are broad enough to cover the whole range of issues that could be made as protected disclosures.

Independent National Officer (INO): If the INO role is created as described in the report then we agree that the CQC is the most appropriate current national organisation for the function to be accommodated within. As stated previously, it will be important to manage the differing roles effectively across teams within the CQC and with the bodies funding its creation if it is to be effective and add value and support improvement.

Role of professional regulator codes: We do not agree that it is necessary to set out how to raise concerns in all of the professional codes that exist. We do think it is relevant to include a statement that registrants have a duty to raise and/or handle concerns in accordance with local protocols. The FTSU report referenced the plethora of guidance available for staff and that we didn't necessarily need more, but to be clear what is expected of all staff and be consistent with that message, which the standard policy and training should provide for employees.

We are also conscious that professional regulators have a UK wide remit, not just England, and registrants work as independent practitioners, in the independent sector, social care, universities, military and voluntary sector to name just a few – not just in the NHS. It is important that the various professional codes are relevant to all.

Contact details for further information

If you would like to follow up about any of the content within this response or explore other issues and ideas with us please contact nyla.cooper@nhsemployers.org or adele.bunch@nhsemployers.org