Board of Directors (open)

Date: 14 November 2018 **Item Ref:** 09

TITLE OF PAPER	**Freedom To Speak Up Guardian (F2SUG) Update and concerns April to September 2018 (Q1/2)**
TO BE PRESENTED BY	**Clive Clarke, Deputy Chief Executive, Director of Operations**
ACTION REQUIRED	For Information

OUTCOME	N/A
TIMETABLE FOR DECISION	November 2018
LINKS TO OTHER KEY REPORTS / DECISIONS	Shaping the Future, the Trust Strategy and Strategic Planning Framework 2017 - 2020 Internal Audit Reports covering Whistling Blowing arrangements
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	We will provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing. A102 Deliver safe care at all times A103 Provide positive experience and outcomes for services users
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	
CONSIDERATION OF LEGAL ISSUES	

Author of Report	Wendy Fowler and Anita Winter
Designation	Freedom to Speak Up Guardian - Associate Director Patient Safety
Date of Report	October 2018

SUMMARY REPORT

Report to: **Board of Directors**

Subject: **Freedom To Speak Up Guardian (F2SUG)**
Update and concerns April to September 2018 (Q1/2)

Author(s): **Wendy Fowler and Anita Winter**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
				✓	

2. Summary

This report is submitted by the Freedom to Speak Up Guardian (FTSUG) to the Board for information and to provide assurance that the Trust is adopting Freedom to Speak Up requirements.

3 Next Steps

- To further embed the FTSUG role within the Trust by developing a programme of announced visits to clinical and non-clinical areas
- To complete the Freedom to Speak Up self-review tool for NHS Trusts and report its findings to the board in February 2019
- To work closely with the newly formed patient safety team to continue to strengthen the FTSU processes including reporting, investigations, closing concerns and learning.
- Communicate the new Freedom to Speak Up Policy and arrangements
- Appoint a Non-Executive Director (NED) with whistleblowing responsibility.

4 Required Actions

The Board to receive the report for information, approval and assurance.

5 Monitoring Arrangements

The FTSUG will continue to meet Kevan Taylor, Chief Executive, Clive Clarke, Deputy Chief Executive and Anita Winter, Associate Director of Patient Safety.

5 Monitoring Arrangements

For further information, please contact:

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Freedom to Speak Up Report

The purpose of this paper is:

- To provide a six monthly report to the Board of Directors, via the Audit Committee in respect of our Freedom to Speak Up activities.

- To update on current and new Freedom to Speak Up (FTSU) requirements from a national and local perspective.

- To provide an overview of the concerns raised through the Freedom to Speak Up Guardian (FTSUG) for the period April - September 2018.

1. Introduction

A governmental response to Sir Robert Francis Report 2015 led to the introduction to the NHS Contract for 2016/17 requiring every NHS Trust to have a local FTSUG from 1 October 2016. Guidance for the appointment of a FTSUG was published in March 2016.

2. Appointment of Freedom to Speak Up Guardian

In October 2016 Sheffield Health and Social Care NHS Foundation Trust (SHSC) appointed Wendy Fowler as the Trust's FTSUG at 7.5 hours a week and the hours have now been increased to 15 hours per week.

3. National Picture

The National Guardian's Office (NGO) is an independent body sponsored equally by the Care Quality Commission, NHS Improvement and NHS England, with a remit to lead culture change in the NHS so that speaking up becomes business as usual. Dr Henrietta Hughes, the National Guardian for the NHS, took up post in October 2016.

One of the NGOs remits is to conduct case reviews with the findings published on its website https://www.cqc.org.uk/national-guardians-office/content/case-reviews

The NGO has published 3 reports:

- Southport and Ormskirk Hospital NHS Trust
- Lincolnshire and Goole NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust

The NGO reviews more than one speaking up case at each site and publishes its recommendations for the trust. So far there have been twelve case reviews. Other trusts are expected to consider if there is any transferable learning. Anyone can contact the NGO to request a case review in their trust. The published recommendations will be reviewed by the task and finish group set up for the purpose of completing component parts of the self-review.

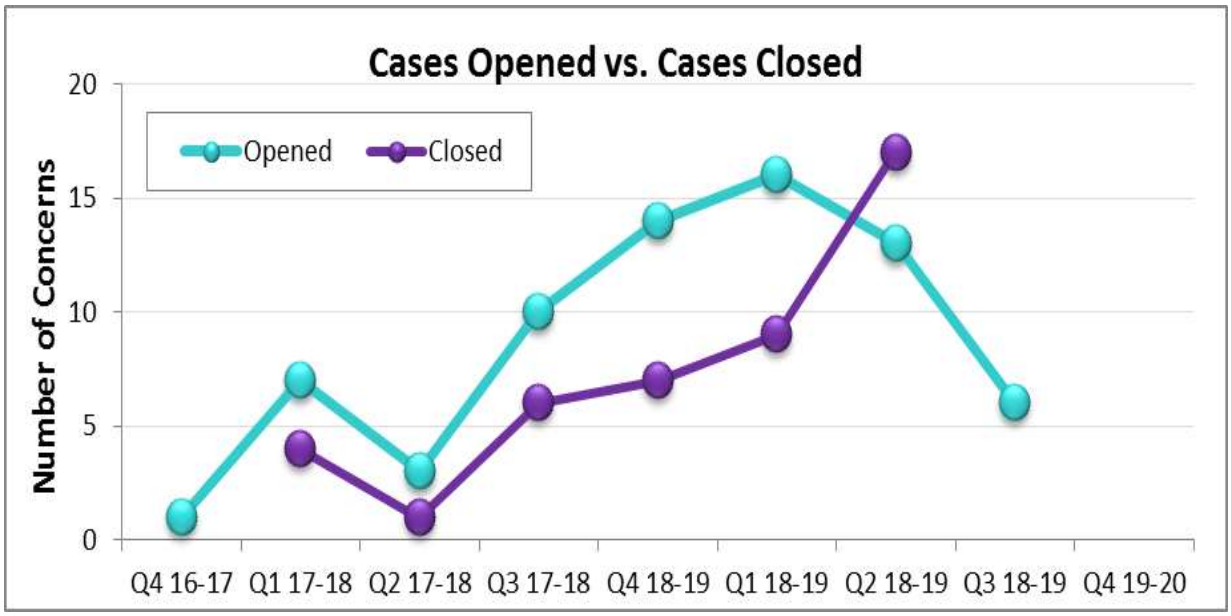
The National Guardian's Office also publishes a quarterly dataset on speaking ups. Out of thirty six comparable trusts we ranked as the 10th highest reporter in Quarter one 2018/19. The highest reporter logged 34 concerns and the lowest was 0.

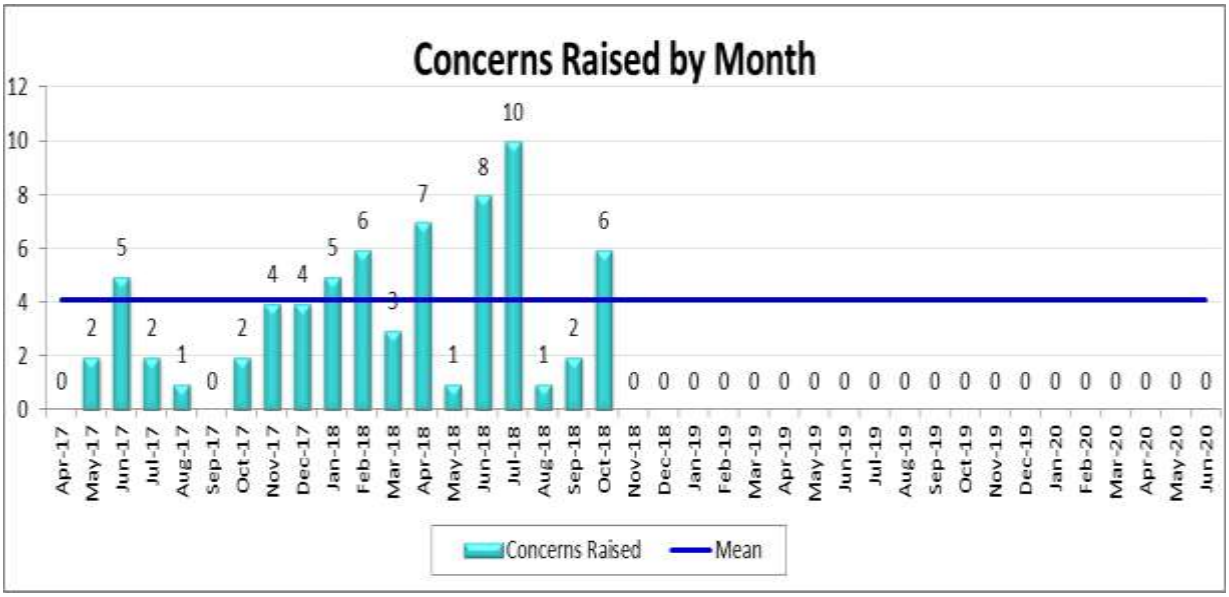
4. Concerns raised 2017/18 National data:

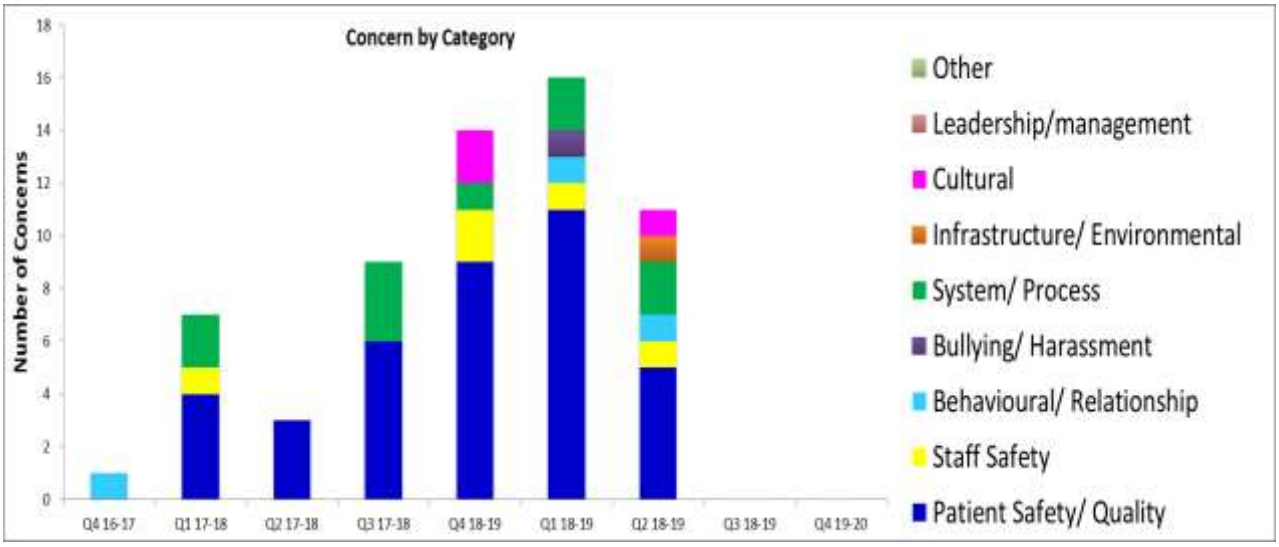
- **3,206** (45%) cases included an element of bullying/harassment
- **2,266** (32%) cases included an element of patient safety/quality
- **1,254** (18%) cases were raised anonymously
- **361** (5%) cases indicated that detriment as a result of speaking up may have been involved
- **6** NHS trusts either did not make a return or reported that they received no cases through their Freedom to Speak Up Guardian in all four quarters.

5. Concerns raised 2018/19 Local data:

- SHSC has only had one case recorded under bullying and harassment.
- In Quarter 1 2018/19 there were 16 concerns raised and 9 were closed
- In Quarter 2 2018/19 there were 13 concerns raised and 17 were closed







Summary of Concerns

Below is a selection of the concerns received in the last 6 months:

Behavioural/Relationships

- Two concerns were raised about unprofessional behaviour. One was directed to HR and the other concern was reported to be in the process of being dealt with internally.

Bullying and Harassment

- The staff member decided not to take the concern further as they had gained employment elsewhere.

Staff/Patient Safety

- A pregnant staff member raised a concern in response to not feeling that the trust had responded adequately after a serious incident. The incident was traumatic and had compromised patient safety. Staff reported that they had felt in fear of their lives during the incident while waiting for the police. The staff member who raised the concern was very vocal in raising her concerns at the time and also tried to raise important learning points to ensure that the incident could not happen again. The staff member did not feel listened to nor did they report they were involved in any debriefing after the incident. This concern is presently being investigated by the patient safety team and the investigation is nearing its conclusion.

- There have been two concerns from inpatient areas that staff have not subsequently raised and this is in part due to them believing they may suffer detriment in doing so. I have spoken to the staff involved and their situations are complicated. It highlights the complexities about raising concerns and how what is considered to be a detriment. It is not just about how trust management responds but also about how colleagues respond as well.

- There have been three concerns raised about the Single Point of Access team. One concern was raised by the alcohol team, another internally and one about 7-day follow ups from inpatient wards. All of these concerns are being responded to and a joint meeting with the Alcohol Team has been scheduled for October 2018. The response for the internal concern will be targeted to the SPA team to help increase transparency and openness.

- A concern was raised by a care coordinator about unrealistic caseloads and the difficulty in providing safe care to a service user who required increased support. Support was offered and other measures were put in place to support clinicians.

- There has been a concern raised about access to the 136 bed and access to inpatient beds.

- A concern was raised about care provided in Darnall Medical Centre. An audit of care is underway and SHSC is jointly working with Primary Care Sheffield to address the present issues. A follow-up meeting has been arranged in November 2019.

- A concern was raised about changes to a rota system. The concern was dealt with locally and the staff member reported that they were satisfied with how the concern was handled.

Systems and Processes

- A concern has been raised about the difficulty in searching for policies. This issue will be discussed in the Policy Governance Group (PGG).

Infrastructure/Environmental

- A concern was raised by a staff member on behalf of patient. However, this concern was already being dealt with within the complaints procedure. The staff member expressed concern over this procedure and advice was given that once the complaint was investigated if they remained unhappy about the outcome then they could appeal this.

Staff Safety

- There has been a concern about how to psychologically protect staff who had to repeatedly witness a traumatic procedure. Staff were provided debriefs and in addition to this psychology support for staff was offered.

Themes

The themes of the concerns are as follows

- **Theme 1** - Access and volume of work in SPA, clinical wards and community teams is perceived to be high.

- **Theme 2 -** Some staff not feeling supported when clinical incidents occur

- **Theme 3** - Staff not formally raising a concern after discussion with the FTSUG

  Observation - Staff report secondary issues of how hard it is to cope with a perceived increase in distressing, disruptive and/or aggressive behaviour at work. This seems to be affecting levels of wellbeing and mental health of staff.

6. Promoting the Role

Communication and promotion of the role is vital to ensure all staff are aware of the FTSUG. October 2018 marks the first “Speak Up” month and there are planned trust activities throughout this time. This includes communications in Kevan Taylor’s monthly letter, FTSUG featured on the carousel and weekly connect articles discussing different aspects of speaking up. This is in addition to presenting an update to senior management meetings and talking to teams.

FTSU posters have been sent to all teams in the service and managers have been requested to speak to staff personally to promote the role and ensure all staff are aware of the role.

An updated ‘Raising Concerns/Whistle-blowing’ Policy was written earlier this year to incorporate national standards and is due to be launched in October 2018. As the FTSU role is still developing the policy will be reviewed shortly to reflect the fast moving changes.

7. Closing concerns and Staff Feedback in respect of Freedom to Speak Up arrangements

Where possible concerns are closed with mutual agreement from the person/people who raised the concern, the Freedom to Speak Up Guardian and the Trust. Where recommendations are made the concern will remain open until the actions have been completed or assurances have been given that they will be done. If the person raising the concern remains dissatisfied, either about the outcome or how the concern was handled, it is proposed that the concern will be signposted to the Chair of Governors and/or the Chief Executive to identify the most appropriate person to review the case.

Once a concern is closed, feedback is requested via Survey Monkey. Feedback is left anonymously unless the person voluntarily states their name. Everyone who has fed back has said they would speak up again. Recent feedback received stated that they felt that their concern had only been addressed in part and left the following comment:

"teams are under-resourced and staff are over-stretched. Unless this is recognised similar concerns may arise again because there is too much expected of individual workers to ensure safe practice"

As feedback has been limited in the number of responses received, everyone who has used the freedom to speak up service will be contacted again for a further request for feedback and this feedback will be presented to the board in February 2019.

8. CQC

The CQC reported that they found evidence that staff were aware of the freedom to speak up role and they found evidence where the Guardian had supported staff to speak up. However, it is important to acknowledge that continued and sustained promotion of the role is vital as some staff in the clinical areas visited are still not aware of the role or how to contact the Guardian.

The CQC also reported that a staff member had reported to them that during an information session a concern was raised that needed further investigation but this was not undertaken. A manager was also present in the information session and neither can recall a concern being raised for investigation. As a consequence contact has been made with the team to request that this concern is raised again either anonymously or confidentially. Unfortunately so far there has been no response.

9. Lead Non-Executive Director (NED)

A Lead NED needs to be identified as the whistleblowing lead.

10. Self-Review Tool and Guidance to the Board

NHS Improvement in conjunction with the National Guardians Office have contacted all the Trust boards in the country and issued them with a self-review tool and guidance for speaking up for boards.

11. Recognition award

The FTSU Guardian is proposing nominating a staff member, who continued to speak up about patient safety concerns, for a recognition award. The present system of the recognition award does not naturally lend itself to nominating people who have spoken up and it might be worthwhile to consider having a separate category.

12. Next steps

The next phase of work will continue to be focused on strengthening reporting structures and how concerns are investigated and closed. Work will also focus on making sure all staff are aware of the new policy, and increasing the visibility of the Trust's FTSUG.

A task and finish group has been set-up to look at component parts of the Freedom To Speak Up Self-Review Tool. Findings will be reported to the board in February 2019 to help inform the FTSU strategy.

13. Required Actions

Work over the next six months as agreed through the Executive Directors' Group (EDG) will focus on:

- Further embedding the FTSUG role within the Trust by developing a programme of announced visits to clinical and non-clinical areas and deliver to workshops at trust conferences where appropriate.

- Completion of the Freedom to Speak Up self-review tool for NHS Trusts and report its findings to the board in February 2019.

- Working closely with the newly formed Patient Safety Team to continue to strengthen the FTSU processes including reporting, investigations, closing concerns and learning.

- Communicating the new Freedom to Speak Up Policy.

- Identifying a lead Non-Executive Director (NED) with whistleblowing responsibility.

- Developing a template board report in line with the national recommendations. This will have a much stronger focus on looking at and reporting on the trusts learning from FTSU concerns raised.

14. In Conclusion

Sir Robert Francis 2015 report highlights the importance of staff speaking up in maintaining patient safety. He also highlights the need for the NHS to become more open and transparent and to adopt a learning culture. In our times of austerity and budgetary restraints his recommendations seem more relevant than ever for NHS organisations.

The concerns received by the FTSUG highlight how much pressure some of the services are under and how much pressure some staff feel. Some concerns highlight that not all staff have felt listened to or felt that the trust has learned from incidents.

The FTSUG will continue to work closely with the safety team to help strengthen the FTSU processes in particular how we listen to and learn from concerns.

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