Freedom to Speak Up Review

Consultation on the implementation of the recommendations, principles and actions set out in the report of the Freedom to Speak Up Review

Ref: 1115

Date: June 2015

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The Freedom to Speak Up Review was set up in 2014 in response to continuing problems around the reporting culture in the NHS, particularly the way NHS organisations deal with concerns raised by their staff, and the treatment of some of those who speak up. The aim of the Review, which was led by Sir Robert Francis QC, was to identify steps that can be taken to enable a culture in the NHS where staff can feel safe to raise concerns as well as confident that they will be listened to and their concerns will be acted upon. This consultation seeks views about a package of measures to implement the recommendations made as part of the Review.

Key points and recommendations

- Age UK supports the implementation of the Freedom to Speak Up Review recommendations. However, we believe these sit within a much broader context around staff involvement and development, which is essential to fostering a culture of openness and commitment to safety. NHS managers have a key role to play in this, through the adoption of a devolved leadership style and development programmes.

- All regulators, commissioners and providers of NHS services should seek to embed the Review's principles within their practices and processes, building on the full range of relevant existing measures such as the NHS Constitution and the new statutory duty of candour.

- Age UK welcomes the suggestion that a 'Freedom to Speak Up Guardian' role should exist within all NHS organisations, as this could help improve the reporting culture and the way cases are handled. There should be a high level of consistency in the name and training provided to the 'Guardians' across NHS organisations so people know who to go to for help, even when moving between organisations.

- However, we would not want to see NHS staff and managers deferring responsibility for responding to safety concerns, and championing patient safety altogether, to the 'Freedom to Speak Up Guardian'. This could not only risk overly formalising and delaying the process, but also undermine progress in changing the culture in the NHS. Staff should be able to raise concerns with any other colleague within the organisation, and be confident that their views will be taken seriously.

1. Introduction

Age UK welcomes this opportunity to comment on proposals for implementing the Freedom to Speak Up Review recommendations. We believe that enabling and empowering NHS staff to speak up about concerns around safety and care practices at work is a key element of securing patient safety.

We welcome the ambition in the Review to foster a culture of openness and commitment to safety and improvement, which is a central part of the work that we have undertaken through the Dignity Commission, jointly with the NHS Confederation and the Local Government Association.

We support the implementation of the Freedom to Speak Up Review recommendations, though they sit within a much broader context around staff involvement and development. As the Dignity Commission's report set out, 'staff who are denied the right training and development, who do not feel valued in their organisation, who are not encouraged by

their managers, and who do not feel that they have the freedom to make the right decisions for patients and residents are far more likely to deliver poor care'[1]. NHS leaders and managers have a key role in achieving this and we welcome this consultation as an opportunity to raise these points.

2. Consultation questions

Q1: Do you have any comments on how best the twenty principles and associated actions set out in the Freedom to Speak Up report should be implemented in an effective, proportionate and affordable way, within local NHS healthcare providers?

In considering this question, we would ask you to look at all the principles and actions and to take account of local circumstances and the progress that has already been made in areas highlighted by "Freedom to Speak Up".

We would recommend utilising the range of existing measures which may encourage, or impose, a responsibility on staff to speak up and protect them when doing so. These include the NHS Constitution, the NHS Terms and Conditions, the new statutory duty of candour, the Fit and Proper Person Test (FPPT) as well as the Care Quality Commission's (CQC) new inspection regime. As such, we would suggest that the CQC requires providers to comply with Freedom to Speak Up principles as part of the registration process, as has been the case for the statutory duty of candour since April 2015, and assesses compliance with those principles, including good reporting practice, as part of its inspections.

We also believe it is important that such principles are embedded within commissioning practices. Building on action 19.1 in the Review, we recommend that all commissioners (national and local) include in their contractual terms with providers of NHS-funded services standards for empowering and protecting staff to enable them to speak up against malpractice. Finally, we recommend that each provider of NHS services clarifies how their board will be held accountable for how concerns are being handled within their organisation. This may include nominating a non-executive director with responsibility for monitoring and improving the reporting culture in the organisation.

We welcome action 2.2 in the Review requiring that NHS England, the NHS Trust Development Authority and Monitor produce a standard integrated policy and procedure for reporting incidents and raising concerns as a means to support NHS organisations in implementing the Freedom to Speak Up principles effectively. However, as there is currently no intention to carry out a public inquiry to complement Sir Robert Francis QC's Review, we would urge national stakeholders to involve both staff and patients in the development of any guidelines relating to the implementation of the Review to ensure they reflect their views and needs when it comes to reporting concerns about patient safety.

In line with the Dignity Commission's report[2], we believe the adoption of a devolved style of leadership, which values staff and respects their judgement, is key to fostering a culture of openness and honesty, where dignified care is the norm. This would mean enabling staff to do the right thing for individual patients, not simply following processes. Behaviour change can only happen if staff not only feel committed to values of patient safety and

[1] Commission on Dignity in Care, *Delivering Dignity – Securing dignity in care for older people in hospitals and care homes*, 2012
[2] Commission on Dignity in Care, *Delivering Dignity – Securing dignity in care for older people in hospitals and care homes*, 2012

dignity and but also believe they can act on them. We believe that NHS managers have a key role to play in ensuring staff feel committed to these values and their role within the organisation. They should encourage active learning and practice-based development programmes within their organisations so that staff build up the confidence to do the right thing in how they care.

Q2: Do you have any opinions on the appropriate approach to the new local Freedom to Speak Up Guardian role?

We welcome Sir Robert Francis QC's suggestion that such a role should exist within all NHS organisations, as this could help improve the reporting culture and the way cases are handled. We believe, however, that it is important that NHS staff are able to raise concerns easily, without formality and at the earliest opportunity, with any other colleague within the organisation, and are confident that their views will be taken seriously.

In line with recommendations from Professor Don Berwick, we believe that all NHS staff should have a duty to 'identify and help to reduce risks to the safety of patients […]'[3]. As such, all NHS staff should feel personally responsible for challenging poor practice as soon as it occurs, and for supporting colleagues who raise concerns over any wrongdoing. We would not want to see NHS staff and managers deferring responsibility for responding to safety concerns to the 'Freedom to Speak Up Guardian'. This could not only risk overly formalising and delaying the process, but also undermine progress in changing the culture in the NHS.

Equally, the recruitment of a 'Guardian' should not exonerate individual NHS managers from their responsibility to understand how safely care is being delivered within their organisation. As set out in the Dignity Commission's report[4], we believe that every non-executive director and senior manager needs to invest time in getting a personal understanding of how care is being delivered. As such, they should talk with people receiving care, their families, carers, advocates as well as their staff. This would help everyone to see that the organisation sees dignified and safe care as a priority.

Q3: How should NHS organisations establish the local Freedom to Speak Up Guardian role in an effective, proportionate and affordable manner?

We would expect NHS England, NHS Employers and Health Education England to work together to issue national guidance on a set of recommended core requirements for the recruitment of 'Freedom to Speak Up Guardians', so that the quality and effectiveness of 'Guardians' is as consistent as possible across the country. However, it is also important that, as well as national stakeholders, efforts are made to involve staff and patients in the development of the guidance to ensure that the 'Guardian' can best respond to their views and aspirations around patient safety and the reporting of malpractice.

Core requirements could, for example, include ensuring that the person demonstrates compassionate values and behaviours, and has a good understanding of patient safety and advocacy as well as of the rights and duties for staff and patients, as set out in the NHS Constitution. We suggest that core requirements for the role are developed in light of

[3] *A promise to learn – a commitment to act: improving the safety of patients in England,* (2013), National Advisory Group on the Safety of Patients in England.
[4] Commission on Dignity in Care, *Delivering Dignity – Securing dignity in care for older people in hospitals and care homes*, 2012

Health Education England's Value Based Recruitment Framework, which seeks to promote the recruitment of staff into the NHS whose individual values and behaviours align with the values of the NHS Constitution.

Q4: If you are responding on behalf of an NHS organisation, how will you implement the role of the Freedom to Speak Up Guardian in an affordable, effective and proportionate manner?

N/A

Q5: What are your views on how training of the local Freedom to Speak Up Guardian role should be taken forward to ensure consistency across NHS organisations?

We agree with the suggestion in Sir Robert Francis QC's report that there should be a high level of consistency in the training provided to local 'Freedom to Speak Up Guardians' across NHS organisations. In line with his recommendations, we suggest that NHS England and Health Education England, in consultation with relevant stakeholders, devise a common structure for training programmes, which reflects good practice, as highlighted in the Review, and the views and needs of staff and the public.

We would also suggest that training materials reiterate the duties, rights and principles enshrined in the NHS Constitution and highlight solutions that are person-centred, compassionate and not task-focused. Additionally, training programmes should consider the mentoring role of 'Guardians' in inspiring staff to feel confident to speak up and challenge poor practice. This may mean signposting those who speak up to counselling and emotional support, as well as recommending appropriate action for those that bully or victimise staff once concerns have been raised.

Finally, in line with Sir Robert Francis QC's suggestion, we recommend the development of a network of 'Guardians' so that they may share good practice and identify common issues and emerging themes, as well as finding support beyond the organisation they work for. The Independent National Officer could play a useful role in facilitating this, and utilising the knowledge shared among 'Guardians'.

Q6: Should the local Freedom to Speak Up Guardian report directly to the Independent National Officer or the Chief Executive of the NHS organisation that they work for?

We believe it is important that 'Freedom to Speak Up Guardians' report to the Independent National Officer to protect their independence and ensure that information is consistently collated and shared at the national level.

Q7: What is your view on what the local Freedom to Speak Up Guardian should be called?

We would recommend that the name is as standardised, consistent and simple as possible across all NHS organisations so that NHS staff know who they can formally report their concerns to, even when they move between organisations. Choosing a standard name that applies across healthcare settings is also essential to ensuring that the 'Guardian' role has a clear identity that is known by the public. As such, the fact that this role exists should be immediately obvious to anyone raising a complaint or concern about care delivered by the NHS. It is also important that NHS providers take appropriate measures to raise

awareness of who the local ‘Guardian’ is within their organisation, to encourage an open and transparent reporting culture (see also response to Q9).

Q8: Do you agree that the Care Quality Commission is the right national body to host the new role of Independent National Officer, whose functions are set out in principle 15 of the Freedom to Speak up report?

Yes. The Care Quality Commission seems to be an adequate host for the role of Independent National Officer, given its responsibilities relating to safety and quality of care. This could help to ensure that issues raised with the Independent National Officer are reflected in the CQC’s inspection decisions, and that the inspection system is overall more responsive to concerns raised by NHS staff and further encourages changes in NHS organisations’ reporting culture.

Q9: Do you agree that there should be standardised practice set out in professional codes on how to raise concerns?

Yes. We agree that setting this out clearly within professional codes would help to embed a culture of openness and transparency as well as clarity on who to turn to when they have concerns about safety and quality of care, wherever it is being delivered. However, beyond professional codes and in line with principle 10 in the Review, we also believe it is important that NHS organisations provide appropriate mandatory training to all their staff on raising concerns, both formally and informally, and on what to do when they have or receive concerns. Such training should be coordinated by the ‘Freedom to Speak Up Guardian’ and reiterate the rights, principles and values of the NHS Constitution.