*Agenda Item No.21a*

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

## REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

| RESPONSIBLE OFFICER: | REPORT FOR: | | IMPACT ON BUSINESS: | | |
|---|---|---|---|---|---|
| David Trevanion, Freedom to Speak Up Guardian | Decision | | High | Med | Low |
| | Discussion | ✓ | ✓ | | |
| | Information | | | | |
| **LEAD MANAGER:** | **REPORT TYPE:** | | **BAF REFERENCES & RAG:** | | |
| | Strategic | | | | |
| | Operational | ✓ | | | |
| | Governance | | **RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)** | | |
| **PEER ASSIST:** | **PEER REVIEW:** | | | | |
| FTSU – NED Oversight, Mandy Ashton | | | | | |
| **CQC Domain: (safe, caring, effective, responsive, well-led)** | Safe, caring and well-led | | | | |

**Meeting Date: 29th January 2019**

**Report Title: 6 monthly review of the work of the Freedom to Speak Up Guardian (FTSU Guardian)**

**PURPOSE:** In line with national guidance and CQC 'Well-Led' criteria, this paper makes proposals to contribute to the further development of the Trust's patient safety and anti bullying culture through its encouragement of staff, who have concerns, to speak up safely and with confidence.

**Summary:**

The Report provides first impressions of the perspective of the FTSU Guardian on the culture of the hospital with particular reference to the most recent CQC report, a summary of cases referred to the FTSU Guardians over the last 6 months and looks at areas of opportunity for learning.

**RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):**

| Strategic / External | Operational/ Organisational | Financial | Clinical | Legal/ Regulatory | Reputational / Patient Experience |
|---|---|---|---|---|---|
| ✓ | ✓ | | ✓ | ✓ | ✓ |

**RECOMMENDATION/S:**

- That Executive Directors and Non Executive Directors should evaluate best ways of listening to staff and feeding back to them, with relevant CQC evidence in mind.
- That the recommendations of the Deputy Director HR, referred to in the body of the report and Appendix 1 are put into action.
- That the FTSU Guardian discusses any confidential matters from which learning can be put into action with relevant Executive Directors, including the Chief Executive

## 1. CQC Report findings on Culture of the Hospital

The September 2018 CQC evidence appendix report stated in the section on Culture (pp 9-13) that:

- Staff awareness of the FTSU Guardian was inconsistent across services.

- Most staff felt they could raise concerns without fear of retribution. However staff also overwhelmingly stated that whilst they raised concerns nothing seemed to happen and that appropriate learning and actions were not undertaken.

- The CQC report cited problems in the maternity service in considerable detail.

Since the appointment of the current FTSU Guardian in September 2018, there has been another big campaign to raise awareness of the role of the FTSU Guardian through leaflets, large posters and on the intranet. A walkabout survey in December 2018 by HR staff found that 70% of 151 staff across a wide cross section of the hospital knew who the Guardian was and 82% said they knew how to get in touch.

However, it is not currently possible to report a similar improvement in staff feeling that anything happens as a result of their speaking up. In early December 2018, 66 staff attended sessions called "Who can I tell?" run by the Deputy Director HR. Individual anonymous responses demonstrated that the majority of staff attending the sessions didn't feel they were listened to, felt that nothing will be done as a result of speaking up and 25% felt they might suffer repercussions. A nine point action plan has been produced by Kristina Risley, Deputy Director HR, which includes role modelling of good management and values-based leadership development. This plan was agreed at the Workforce Committee in January 2019. The Committee will make arrangements to evaluate and monitor how the actions are impacting on the organisation and how this work complements and supports the Trust's work on organisational / cultural development (see Appendix 1).

### 2. Cases referred to FTSU Guardians

Mandy Ashton, Non Executive Director, covered the role of FTSU Guardian up until August 2018, and continues to provide NED oversight on FTSU Guardian matters. She reports that:

- An independent expert was appointed to conduct an investigation into matters relating to Maternity Services. This was concluded in November 2018. Recommendations from this investigation have been wholly accepted by Emma Hardwick, Chief Nurse, and integrated into the wider Maternity Quality Improvement Plan. The current FTSU Guardian will continue to offer monitoring and support. At the next report we will be able to demonstrate what has changed in maternity as a result of the FTSU Guardian investigation.

- Two other FTSU Guardian matters were formally stood down by Amanda Ashton with staff members pursuing their concerns by way of QEH employment policies and procedures.

The current FTSU Guardian has to date received three referrals as reported to the December Board:

i. Anonymous referral concerning the safety and risk of patients because of difficulties in referral to other hospitals in the region, e.g. patients with burns referred to Broomfield Hospital. Discussed in full detail with Medical Director, who explained that this is an ongoing issue, which is currently hard to resolve. When this was fed back to the referrer they felt frustrated that not enough explanation and feedback is given when issues are raised. Learning - Raises issue of how hard to resolve issues are fed back to front line staff, how the loop is closed in FTSU situations.

ii. Nursing assistant on sick leave following disagreements with colleagues and manager. Discussed range of options open to her, following which she decided to entrust her union to help her. No further action.

iii. Member of staff who felt that she had been inappropriately redeployed out of her current role onto another ward, because she had spoken up about patient safety and lack of availability of consultant on her ward. Her union has taken up her case. Freedom to Speak Up Guardian still involved. Learning from this case will be communicated as soon as the matter is resolved – this is likely to be significant as the morale of staff and culture of the hospital has been affected by this case.

**National Guardians Office**

As FTSU Guardian I attended the course for new Guardians in September 2018 and I provide the quarterly return to the National Guardian's Office, due this month, January 2019. This will enable me to demonstrate how the Trust benchmarks against other hospitals in future.

The National Guardians Office also provides the opportunity for me to consult confidentially, about particular speaking up cases – I have used this facility on one occasion. It is particularly useful, bearing in mind that my appointment enables and requires me to work independently.

**3. Recommendations**

- That Executive Directors and Non Executive Directors should evaluate best ways of listening to staff and feeding back to them, with relevant CQC evidence in mind.
- That the recommendations of the Deputy Director HR, referred to in the body of the report and Appendix 1, are put into action
- That the FTSU Guardian discusses any confidential matters from which learning can be assimilated, with relevant Executive Directors, including the Chief Executive.

**Appendix 1 – Who Can I Tell Action Plan**

| Action | Owner | Timescale |
|---|---|---|
| Review with lead responsible for each avenue of reporting (e.g. DATIX, HR, Freedom to Speak up Guardian, whistleblowing hotline) – how can we regularly report back that things have happened and "close the loop"? | Deputy Director of HR | End March 2019 |
| Review and relaunch of whistleblowing hotline | Head of Communications | End February 2019 |
| Further promotion of Freedom to Speak up Guardian role | Head of Communications | End February 2019 |
| Include development about role-modelling good management of concerns in Board development | Deputy Director of HR | End April 2019 |
| Targeted work with senior managers to highlight the importance of good role-modelling and ensure all adopt a consistent approach | Executive Directors | End June 2019 |
| Leadership development initiatives to be values based and include best practice about managing situations where concerns are raised | Deputy Director of HR | End September 2019 |
| Relaunch values awards, with criteria focused on openness, transparency and courage to raise concerns | Deputy Director of HR | End February 2019 |
| Regular reporting on how the Trust is responding to concerns (e.g. DATIX, HR, Freedom to Speak up Guardian, whistleblowing hotline) | Deputy Director of HR | January Workforce Committee then quarterly |
| Inclusion of raising concerns session on Trust induction | Deputy Director of HR | End April 2019 |