National Guardian
Freedom to Speak Up

Southport and Ormskirk Hospital NHS Trust

A case review of speaking up processes, policies and culture

Contents

Executive summary

In August and September 2017 the National Guardian's Office conducted a review of the speaking up processes, policies and culture at Southport and Ormskirk NHS Trust. This was because it had received information that the trust's response to its workers speaking up was not in accordance with good practice.

In particular, the National Guardian's Office received information that a bullying and discriminatory culture existed across the trust.

The purpose of the review was to find evidence of where speaking up process, policies and culture did not meet with good practice and to make recommendations to remedy this. The trust fully supported the review and provided all necessary information for its completion.

The review found evidence that the culture, policies and procedures of the trust did not always support workers to speak up, including evidence of a bullying culture. Many workers who spoke to the National Guardian's Office during the review expressed a belief that the trust did not take their views or concerns seriously.

The review also found that the trust did not appropriately support the needs of its black and ethnic minority workers, including a failure to respond to multiple and serious concerns raised by many of those workers.

However, there was also evidence at the time of our review that a new trust leadership team was taking steps to improve the trust's speaking up processes, policies and culture, including a revision of the existing speaking up policy to bring it in line with national minimum standards set by NHS Improvement.

Where we found evidence that the trust's support for speaking up was not in accordance with good practice we have made recommendations to improve this. We have made 23 recommendations in total; 22 for the trust and one for the Care Quality Commission. We will ask the trust to develop an action plan to address these recommendations.

Our findings can be summarised as follows:

There were several important areas where the trust's support for its workers to speak did not meet with good practice. These areas included:

- Evidence of a longstanding culture where the trust did not respond appropriately to specific and serious concerns raise by its workers
- Significant evidence of a bullying culture within the trust where staff were too afraid to speak up, or they alleged detriment at the hands of their colleagues for having done so
- Failure of the trust to meet its responsibilities regarding equality and diversity resulting in black and ethnic minority staff not feeling free to speak up

- No specific training for staff on either how to speak up, or for managers to handle concerns raised according to the policies and procedures of the trust
- Persistent failure by the trust to feedback to staff regarding any actions it had taken in response to workers' speaking up, creating a widespread belief among staff that the trust did not take their concerns seriously
- Since appointing a Freedom to Speak Up Guardian in August 2016 the trust had not provided all the necessary resources to support the role, including adequately promoting it across trust sites
- The trust did not have a systematic approach to measure the effectiveness of its speaking up policies, procedures and culture
- Many workers regarded most of the trust's senior leaders as invisible and inaccessible

There were also examples of where the trust was taking positive steps to support speaking up. These included:

- The trust was in the process of revising its speaking up policy to bring it in line with minimum standards set out by NHS Improvement
- The trust was in the process of developing a detailed freedom to speak up action plan to ensure that its speaking up processes, policies and culture were in accordance with the principles and actions set out in Sir Robert Francis' Freedom to Speak Up review
- There was evidence that the trust's interim chief executive officer was taking steps to improve the speaking up culture and many workers told us they could see that the interim chief executive's leadership was beginning to make a difference

Acknowledgements and thanks

In completing this review we would like to thank the following individuals for their engagement and support:

- Trust workers who have told us about their experiences of speaking up
- The leaders of the trust
- The trust's Freedom to Speak Up Guardian
- Care Quality Commission

Introduction

The National Guardian's Office

The National Guardian's Office provides leadership, support and guidance on speaking up in the NHS, and was set up in response to recommendations made in Sir Robert Francis' 'Freedom to Speak Up' review. It supports and guides a network of Freedom to Speak Up Guardians and reviews cases where good practice in speaking up appears not to be met.

The Francis review set out 20 principles and actions to enable NHS workers to speak up freely at work, without fear of detriment, and to ensure that workers' concerns are responded to appropriately. These principles are designed to create a safer and more effective service for everyone.

Principle 15 of the review set out the terms for the role of a National Guardian and the National Guardian's Office to support this work and to bring about a positive culture change in speaking up across the NHS.

The full Francis Freedom to Speak Up report can be found here.

The National Guardian's Office is an operationally independent body, sponsored by NHS Improvement, NHS England and the Care Quality Commission.

Case reviews

As part of its work the National Guardian's Office reviews how a NHS trust or foundation trust has supported its workers to speak up, where it receives evidence that this support has not met with good practice.

The standards of good practice against which the NGO assesses the actions of trusts are found the Francis Freedom to Speak Up review and the standard, integrated Freedom to Speak Up policy published by NHS Improvement.

The National Guardian's Office is currently undertaking a 12 month pilot of its case review programme, which began in June 2017. At the end of the pilot it will review the process to see how it can be improved. It will use all the feedback it receives during the pilot, including from individuals who have referred cases, to ensure that the case review process meets the needs of all workers who wish to speak up.

The primary focus of a case review is on extracting as much learning as possible relating to how speaking up processes and cultures can be improved and the likelihood of obtaining such learning is one of the principal selection criteria the National Guardian's Office applies when deciding which cases to review.

Learning may not only arise from evidence of a trust's lack of support for speaking up, but also where a trust demonstrates innovative and effective support for speaking up that should be shared across the NHS.

Where the National Guardian's Office finds evidence during a case review that a trust's support for speaking up has not met with good practice it will make recommendations about how the trust should improve this. A case review report will also highlight where the office has found examples of good practice.

More information about National Guardian's Office case reviews is available on our webpages.

The National Guardian's Office publishes its case review reports on its webpages and ensures that they are shared with individuals and bodies with a direct interest in the review process. These include trust workers who have contacted us about their speaking up experiences, the trust itself and regulatory bodies with responsibility for ensuring the trust delivers care and treatment according to accepted standards.

To conduct a case review the National Guardian's Office works with the trust in question to identify relevant information and to feedback learning as it arises.

Why we conducted a case review at Southport and Ormskirk NHS Trust

The National Guardian's Office received information that the response of the trust to several instances of its workers speaking up was not in accordance with good practice. The National Guardian's Office received evidence that many workers had raised a range of concerns relating to bullying and discrimination against black and minority ethnic staff that had been ignored. The information indicated that the practices and cultures of the trust frequently did not support its staff to speak up.

The information relating to these concerns also included a public statement by the trust released in June 2017 that its previous chief executive had been dismissed in October 2016 following allegations that he had 'failed to comply with the trust and the NHS's conduct requirements in his approach to whistleblowing complaints.'

Feedback from the published NHS staff survey in 2016 also confirmed that many workers were not content with the support they received from the trust to speak up, including responses relating to their perception of the fairness and effectiveness of procedures to support speaking up that were worse than the national average. A significant number of black and minority ethnic doctors also indicated in their survey responses that they had experienced bullying.

Because of the information received by the National Guardian's Office, as well as published information relating to speaking up, it undertook a wide-ranging review of how the trust was supporting its staff to speak up.

How we conducted our review

We made three visits to the trust during August and September 2017 to meet with trust staff and visited both trust sites at Southport and Formby District General Hospital and at Ormskirk and District General Hospital. During those visits we met with a total of 52 workers of the trust, including the chief executive and board members to learn how they intended to support the trust's workers to speak up.

We also met front line staff, including nurses, doctors and ancillary staff to hear their experiences of speaking up, as well as with ward managers with responsibility for handling the issues raised. We also met with the trust's newly appointed Freedom to Speak Up Guardian to learn how the trust supported its workers to speak up and toured the wards at Ormskirk hospital with the Guardian as they introduced themselves to staff and asked them about their experiences of speaking up.

We held a total of six staff forums across both hospitals, including a forum specially for black and minority ethnic staff, to provide an opportunity for trust workers to tell us about their experiences of speaking up.

In addition to forums and one to one meetings, trust workers were also able to contact us directly. We worked with the trust's internal communications team to promote the case review to its workers.

We reviewed a range of documents relating to speaking up in the trust, including trust policies, procedures and strategies, as well as staff surveys. We also looked at a cultural review commissioned by the trust in April 2016 in response to concerns raised by trust workers relating to the treatment of black and minority ethnic staff.

In addition, we asked other bodies to share what they knew about the trust's support for speaking up, including the Care Quality Commission and NHS Improvement.

Where we found issues we immediately raised them with the trust to allow them to address them as quickly as possible.

Recommendations and actions

Where we found evidence that support for speaking up was not in accordance with good practice we have made recommendations on how to remedy this. 22 of our recommendations are for the trust and one is for the Care Quality Commission.

A list of our recommendations is set out in the Annex to this report.

Where the trust has already begun to take steps to address our recommendations we have stated this. We have also asked the trust to produce an action plan in response to our recommendations and we will publish this once we receive it.

To support the trust to implement our recommendations we will advise regulators of the actions the trust are taking in response, to ensure the trust receives all appropriate guidance to complete this work.

The structure of this report

We have set out the information we gathered during our review under four main headings: culture, the handling of concerns, supporting good practice, and vulnerable and minority groups.

About the trust

Southport and Ormskirk trust has two hospitals, Southport and Formby District General Hospital and Ormskirk and District General Hospital. The trust provides acute hospital care and community services to the populations of Southport, Formby, Sefton and West Lancashire and employs 2,900 staff.

The trust was most recently inspected by the Care Quality Commission in April 2016 and received an overall rating of 'Requires Improvement'.

According to the Care Quality Commission's inspection process the category of work related to how the trust supports its workers is defined as 'Well Led'. The Care Quality Commission rated 'Well Led' as 'Requires Improvement'.

A link to the inspection report, published in November 2016 can be found here.

Our findings

1. Culture

Culture of Raising Concerns

Policies and procedures

The trust's policy relating to speaking up was entitled 'Raising Concerns (Whistleblowing) Policy'. At the time that our case review began in August 2017 the trust had last reviewed the policy in September 2014. During our review the trust undertook a revision of its policy to bring it in line with the minimum standards set out in the standard, integrated freedom to speak up policy published by NHS Improvement in April 2016.

The trust informed us that the revised new policy would be available from the middle of October 2017. However, there was no information indicating how the trust would ensure that all workers were aware of the contents of the new policy.

Recommendation 1

Within three months the trust should publish its new speaking up policy.

Recommendation 2

Within six months the trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.

Senior leadership and culture

There was evidence from the NHS 2016 trust staff survey that many workers did not regard the speaking up processes in the trust be fair or effective. We therefore asked senior leaders about their perception of the speaking up culture and what steps they intended to take to address the concerns raised in the survey.

The senior leaders explained that most of the trust's senior management team had been appointed recently and all shared the intention of making improvements in the trust, including to the speaking up culture. Some leaders conceded that the culture had previously not been a positive one. Trust leaders explained the steps they were planning to take to improve the speaking up culture. Firstly, the trust planned to hold a series of listening events in autumn 2017 to better understand the views of all staff and to provide an opportunity for them raise any concerns they wished. This included a 'speak up safely campaign'. A principal purpose of these events was for senior leaders to learn the concerns of staff in order to respond to them.

In addition to the listening events, senior leaders also highlighted that the trust had, during our review, appointed the trust chaplain, an individual they regarded as a well-respected and familiar

employee to many workers, as the new Freedom to Speak Up Guardian. Senior leaders said that the guardian was free to meet with them to discuss concerns they were supporting workers to raise. The guardian confirmed that this was the case.

The new Freedom to Speak Up Guardian replaced the previous guardian, who the trust had appointed to the role in August 2016 and who had left the trust 12 months later.

At the time of our review the trust was also drafting a Freedom to Speak Up action plan, to ensure that the trust implemented the principles and actions stated in the Francis Freedom to Speak Up review. The expected completion dates for the actions in the plan ran from October 2017 for 12 months with a committee from the trust board next due to review its progress in December 2017. The National Guardian's Office will liaise with the trust's Freedom to Speak Up Guardian to monitor whether the draft plan is put into effect and if the planned actions take place.

We asked workers about their experiences of the speaking up culture in the trust. In response, many felt that the culture in the trust in recent times had not always been positive and that they did not always feel listened to, but that they hoped this would change with the appointment of the guardian.

Recommendation 3

Within 12 months the trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates.

Culture of valuing workers

There was evidence that the trust had previously provided opportunities for staff to give their views about working in the trust. These included surveys, forums and focus groups. Further staff listening events were also about to begin at the time of our review as part of the Listening into Action programme.

However, many staff expressed frustration that although the trust had provided an opportunity for them to speak up at certain points, the culture was not a positive one when it came to the trust responding to their concerns and taking appropriate action. Some described listening events as mere 'gimmicks' and did not think that speaking up at such events made any difference. Another worker observed 'there are some really good ideas that come out of these sessions but nothing is done with them'.

A senior trust leader also observed that the way in which the trust responded to the views it obtained from its workers was 'poor' and as a result staff sometimes felt that nothing was done once they had spoken up.

However, all senior leaders that we spoke to emphasised that the board was mostly comprised of new members who were committed to improving the speaking up cultures, policies and procedures in the trust and they all felt confident that they were beginning to make those changes.

Many workers told us that the most important step the trust could take to improve the speaking up culture in the trust was to provide feedback once someone has spoken up.

Providing feedback to a worker who has spoken up is an essential element of good practice. The commitment to providing feedback is also set out in the trust's new speaking up policy.

When we raised workers' frustrations about the lack of feedback to senior leaders, they told us that they had recently amended the electronic system used by staff to record incidents, which is a principal way in which they are able to raise a safety incident. The amendment allows the individual recording an incident to request feedback on how it was responded to.

The majority of staff said they believed that the interim chief executive of the trust wanted to make positive changes to the trust, including responding to the needs of workers.

However, many also said that such changes could not be achieved by one person alone. Several described a tier of middle and upper management who were not responsive to the concerns of staff and who represented a block upon positive changes.

Recommendation 4

Within three months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.

Measuring the effectiveness of speaking up processes

We asked senior trust leaders how they intended to measure the effectiveness of speaking up cultures, policies and processes to ensure that they were meeting the needs of trust workers and promoting a positive speaking up culture.

Senior leaders explained that the trust kept a register of concerns it determined were 'whistleblowing' matters, which was maintained by the company secretary. It was then the responsibility of the audit committee of the board to review the cases on that register to assess whether all necessary actions in relation to them had been taken.

However, it was not clear from the information provided how the trust determined whether a concern that was raised was a 'whistleblowing' matter or not. Senior staff we asked about this also conceded that the register was not intended to record all types of concerns that workers raised.

In addition, although all senior leaders accepted that it would be important to monitor the effectiveness of the trust's speaking up processes they did not provide any specific examples of how they intended to do this, other than assessing the anonymised information gathered from the Freedom to Speak Up Guardian.

Good practice to support speaking up includes effective and continuous monitoring of speaking up culture, processes and policies to ensure that the response to speaking up is effective and the organisation is taking all necessary steps to develop and maintain a positive speaking up culture.

Trusts can make informed choices about which data they may best use to monitor their speaking up culture. Such information can include data from staff surveys, reports from Freedom to Speak Up Guardians, information from staff grievances, staff retention data, feedback from staff at exit interviews and independent audits of speaking up processes.

Recommendation 5

Within six months the trust should put in place effective systems to monitor the development of a positive speaking up culture.

Culture free from bullying

Policies and procedures

The trust had a dignity at work policy to address incidents of bullying and harassment. In line with good practice the policy set out clearly defined standards of acceptable behaviour and a zero tolerance of bullying behaviour.

Culture

However, there was evidence of a bullying culture in the trust, as reflected by the 2016 NHS staff survey, the trust's own cultural review, as well as the experiences of some of the staff we spoke to.

In the survey the number of staff reporting that they had been bullied by colleagues was higher than the national average. Further, the author of the cultural review commissioned by the trust in April 2016 reported that they witnessed levels of fear caused by bullying among the staff they interviewed that was unprecedented in their own experience. This was especially in the case of black and minority ethnic staff.

Four workers also told us they had been the victims of bullying and all said this had happened because those who bullied them did not like the fact they had spoken up.

Several workers also told us that they had witnessed a culture of bullying at the trust and gave examples of how this occurred. They said that managers had their favourites and if they did not like a worker that they managed they would deliberately treat them less favourably than other staff. Such treatment could include unreasonably refusing to grant a request for leave, or giving individuals more difficult shifts than their colleagues.

Many workers also said that the culture of favourable treatment extended to a culture of cronyism, where managers in the trust sought only to appoint colleagues into positions where they personally favoured them, instead of following a fair and open recruitment process. This is discussed further below.

However, the majority of staff we spoke to said that, although they were aware of allegations of bullying, they had not personally witnessed such behaviour. Many workers, including front line staff and ward managers also commented that they believed that the culture in the trust was changing in recent months, following the appointment of new senior leaders in the trust who were helping to create a more positive working environment.

Despite the allegations of a bullying culture set out in detail in the cultural review and reported in the staff survey, the trust did not have a strategy or action plan to address these serious concerns. This was not in accordance with good practice and the reports of a bullying culture strongly indicated that not all workers believed they had been free to speak up without fear of reprisals.

Training

Good practice in relation to addressing bullying cultures requires managers and leaders to receive regular training on how to address and prevent bullying, and should provide information on how such behaviour impacts on individuals.

NHS Employers, the national body which acts on behalf of NHS trusts, also provides guidance to trusts regarding developing positive anti-bullying cultures, which advises that trusts should provide their workers with appropriate training.

This guidance can be found here

However, the trust did not provide specific training relating to bullying and harassment, either in respect of how to speak up about bullying and harassment or how to appropriately handle concerns. The only reference to such training in the trust's dignity at work policy was a description of the need for 'all managers […] to implement this policy and bring it to the attention of staff in their work area …' without providing support for the managers to do this.

Managers that we spoke to confirmed that they received no training to manage bullying and agreed that such training would be helpful.

Therefore, it was clear that not only would anti-bullying training fulfil an important requirement of good speaking up practice, but would also support the more positive working cultures that the new trust leadership was beginning to put in place and which many staff were noticing.

Recommendation 6

Within 12 months the trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.

Culture of visible leadership

Management support for workers

The accessibility of senior leaders to all staff is an important aspect of a positive speaking up culture. Leaders' visibility in the workplace, and their availability for workers to meet with them, confidentially if necessary, promotes confidence that those leaders value their workers' views and will respond to them.

We asked staff at both the Southport and Ormskirk hospital sites if they had access to senior managers to raise concerns and whether senior leaders of the trust visited their workplace to engage with them. Most workers replied that although the new chief executive officer had visited the workplace, they had rarely seen other members of the executive team.

Several staff at Ormskirk and District General Hospital said that they had not seen any senior leaders and some commented that they thought the leaders of the trust were not interested in learning their views. They added that because most senior staff were based at the Southport site this meant that they neglected to attend the Ormskirk site to learn the views of workers based there.

This caused some staff particular anxiety as they had concerns about the future of some services at the site, but felt uncertain as to their future.

When we raised the issue of visible leadership with senior trust staff they responded that they were putting in place from September 2017 a programme of visits to trust sites, undertaken by every executive director accompanied by a non-executive director. The purpose of these visits was for the directors to assess the quality of services and to speak to workers.

This new programme of directors' visits was evidence of the trust leadership's actions to transform the speaking culture referred to in our executive summary.

Because this programme was in accordance with good practice, but also because it was just beginning, we have recommended to the trust that it undertakes and continues with all such appropriate efforts to promote accessible and visible leadership.

Recommendation 7

Within 3 months trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.

2. Handling concerns

During our case review individual workers from the trust approached us to share their experience of how the trust had handled specific concerns they had spoken up about. Where individual cases fulfilled the National Guardian's Office criteria for reviewing the handling of a case and where the individual concerned gave their consent for us to look into the matter we did so.

The National Guardian's Office's case review criteria can be found here.

For each case we looked into we have provided a short case study below alongside our recommendations.

As with all the narrative in this report there are no references to individuals in order to protect their identity and to ensure that the focus of this case review is on learning how to improve speaking up culture, policies and procedures.

Although some of the events described took place some time ago, they highlight an historic speaking culture that requires change and the learning from them will help assist the new trust leadership to deliver that change.

Case study 1

The information set out below was the version of events given to the National Guardian's Office by an individual working at the trust. When the National Guardian's Office put these matters to the trust they did not provide an alternate version.

Several years ago the staff member spoke up about the potential falsification of patient safety data by a colleague. When the staff member initially raised the matter they were told by a senior manager that the changes to the data were not important.

Because the staff member remained concerned they escalated the matter to a member of the trust leadership, who said that the matter was 'too complicated' for the trust to look into. Instead the trust leader suggested that the worker raise the matter with the relevant regulator.

Upon referring the matter to the regulator, they told the worker they would have to provide evidence to support their allegation, before it could be looked into.

Therefore, as a consequence of the trust's refusal to look into the worker's original concern and following what little advice the trust gave them, the burden to obtain evidence relating to the matter was placed upon the worker themselves.

Faced with this burden, the worker felt that they were unable to provide the regulator with the relevant information.

We asked the regulator what action they then took in the absence of any evidence on the matter from the worker. They told us that, in response, they investigated the concern themselves, although they told us that they could not disclose the outcome of this investigation.

Two years later the trust suspended the worker who had spoken up regarding a disciplinary matter. The investigation that followed found no case to answer against the worker. The worker told us during our case review that they perceived such action as a deliberate and detrimental act against them for having spoken up, although they could not provide evidence to substantiate this allegation.

The trust's response to their worker who spoke up did not meet with good practice. This was because firstly, those with responsibility for responding to the worker's concern chose not to investigate the matter. Secondly, by failing to respond to concern appropriately they then caused the burden for investigating it to fall upon the worker who had spoken up.

We have included the worker's comments regarding their perception of deliberate action against them for speaking up because, although this belief was not confirmed by other information, culture is, in part, driven by perception and it is therefore important for leaders who are acting to change that culture to be aware of workers' negative experiences and perceptions.

Recommendation 8

Within three months the trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.

Case study 2

Trust workers told us about their experiences of speaking up over a long period of time regarding their belief that a culture existed where individuals were appointed into jobs without a proper, fair and open recruitment procedure taking place. Because of this culture it was alleged that many individuals were appointed on the basis of who they knew, instead of being selected for their relevant competence and experience.

The workers who told us about this said that they had raised these concerns on many occasions, but on each occasion the trust, did not provide any feedback about what steps it intended to take in response to the concerns, including whether they would be formally investigated.

The workers added that the trust's failure to properly investigate these allegations over a long period of time contributed to a widespread perception among many workers of a culture of cronyism within the trust.

We asked senior leaders about the allegations. In response, a senior trust member of staff told us that they did not know how the trust had responded to each allegation of improper recruitment, save for a recent allegation that was formally investigated by an external and independent body. In this case no evidence was found of improper recruitment processes and this was fed back to those who spoken up about this matter.

The senior staff member conceded that there were historic allegations about improper recruitment processes, but expressed the hope that with new leadership in the trust seeking to positively change cultures, policies and procedures that staff would have more confidence in the recruitment process.

The senior staff member also gave assurance that the trust would investigate any recruitment practices that appeared not to be in accordance with trust policy and take appropriate action where evidence was found of such practices.

However, although many workers we spoke to confirmed that the trust's new leadership displayed a willingness to develop more positive working cultures, new appointments were still taking place that were not in accordance with a fair, open and honest process.

An example given by workers of this continuing culture was the appointment of the new Freedom to Speak Up Guardian. While many workers expressed confidence in the individual appointed, staff were nevertheless unaware of any advertisement for the role, or a proper recruitment process for it. Instead the trust had merely announced to staff that an individual had been appointed to the role. This is discussed further below.

Recommendation 9

Within three months the trust should ensure that it responds to all concerns raised by its workers in relation to the recruitment of staff strictly in accordance with its policies and procedures and in accordance with good practice.

3. Supporting good practice

Speaking up training

Good speaking up practice includes providing training for all staff so that they know how to speak up and how to respond to and support those who do speak up. This is particularly important for managers whose responsibility is to ensure that they handle all matters raised by the staff they supervise in accordance with good practice, policy and procedure.

All workers we spoke to, including senior leaders, ward managers and front line staff said that they did not receive such training and that it would be very supportive to have it.

In the trust's draft speaking up action plan a section on training was included, although it was not clear from the information provided whether this would include guidance for managers of all levels on how to support and respond to people who speak up.

Recommendation 10

Within 12 months the trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.

Freedom to Speak Up Guardians

In accordance with its standard contract with NHS England the trust had appointed a Freedom to Speak Up Guardian to support workers to raise concerns. The first guardian was appointed to the role in August 2016, who occupied the role for 12 months. During our review the trust appointed a new guardian to the role.

Trust leaders explained that they had asked the trust chaplain to undertake the role as their existing chaplaincy role meant they already had significant experience in providing independent support for trust workers across a range of issues. Many trust workers we spoke to said they knew the chaplain and thought they were a good choice for Freedom to Speak Up Guardian.

However, some staff expressed concern that the trust had not undertaken an open recruitment process and had appointed them without providing the opportunity for workers to apply for the role. Two members of staff commented that the trust's decision to appoint a guardian without following any recruitment process was another example of senior managers choosing to appoint individuals they preferred, rather than following correct recruitment procedures.

National Guardian's Office guidance to trusts regarding the appointment of guardians advises that this should happen 'in a fair and open way'.

See the following link for this guidance.

We asked trust leaders why they had appointed a Freedom to Speak Guardian without following a recruitment process. In response they explained they had been keen to ensure that the role was

promptly filled following the departure of the previous guardian and had selected an individual they reasonably believed the majority of staff would support.

In addition, trust leaders pointed out that their choice to appoint the chaplain is something they had first discussed with us in August and at that stage we did not comment on their process. This was because we only formulated our guidance after that conversation, in September, following data we collected from our Guardian survey.

The leaders acknowledged that, on reflection, some staff may be unhappy about the absence of a recruitment process and undertook to adopt different methods in future, both in respect of the guardian as well as any staff appointed to support the guardian role.

We accept that the trust leaders acted as they thought best at the time and with our knowledge, so we do not seek to criticise the way in which the appointment was made. Instead our recommendation below asks the trust to look again the process, in light of our new guidance, but within a time frame that does not place an unreasonable burden upon the trust.

Although the trust had first appointed a guardian in August 2016 many staff we spoke to had not heard of the role. When we spoke to the trust employee who had occupied the role for the first year they acknowledged that the trust needed to do more to promote it. During our review we also noted that there were no visible advertisements of the role on the wards, or other trust locations, which could serve not only to promote it among staff, but also among patients, for whom they could serve as reassurance that the trust was supporting the staff responsible for their care to speak up.

In response, trust leaders said they were putting in place a communications strategy to inform staff about the guardian, which included a formal announcement of the appointment on internal staff communications networks and visible communications throughout the trust to be displayed from October 2017.

The trust's draft speaking up plan provided for additional roles to support the guardian, although the completion date for the appointment of these roles had not been reached at the time of our review. It was therefore not clear what support was available for staff to speak up in the absence of the guardian.

The National Guardian's Office guidance on the appointment of guardians states that trusts should ensure that minority and vulnerable staffing groups receive particular support to speak up. We detail later in this report how we found evidence that minority staff, especially black and minority ethnic (BME) workers, had experienced discrimination.

Because of this evidence we asked trust leaders how they supported BME workers to speak up. The leaders said that staff engagement groups existed for minority staffing groups, including BME workers, although these were rarely well attended.

As neither the previous nor the newly appointed guardian was a BME worker and because supporting vulnerable and minority staff was not specifically addressed in the trust's speaking up policy or draft strategy, it was not clear how the trust would assure itself that BME workers would receive this support.

Recommendation 11

Within three months the trust should ensure that appropriate steps are taken to publicise the role of guardian and any staff supporting that role, using methods that reach all workers.

Recommendation 12

Within three months the trust should ensure that it provides appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the National Guardian's Office, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts.

Recommendation 13

Within three months the trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers are free to speak up.

Recommendation 14

Within six months the trust should look again at its appointment process for the role of Freedom to Speak Up Guardian and ensure a Guardian is appointed using a process that is open and fair.

Transparency

In accordance with good practice, organisations should publish information relating to concerns that their workers speak up about and the actions they have taken in response to those concerns.

As described above, the trust commissioned in April 2016 a cultural review to assist it in developing its approach to equality and diversity. The review had been prompted, in part, by concerns raised by some BME staff that they had experienced discrimination in the trust. The review was completed in June 2017.

At the beginning of our case review the trust shared the report with us so that we could learn about the cultural review's findings. The report described in detail the experiences of bullying alleged by workers, the fear that some staff had described about speaking up, governance failures in responding to that fear, bullying, and an overall culture in the trust that, to many of those interviewed for the review found to be 'elitist', 'insular' and which was characterised by 'nepotism'.

At the time of the publication of this report five months have passed since the completion of the cultural review. However, the trust had not yet published any part of this report. Instead, its contents had only been disclosed to a small number of trust leaders. This did not include the Freedom to Speak Up Guardian, despite the fact that the report contained very detailed information relating to significant failings in the trust's speaking up processes and the lessons learned from those failings.

The review detailed many lessons to be learned from its findings and set out recommendations to implement its findings.

Most of the workers we met with knew of the review and did not understand why the trust had not disclosed any of its contents. Some staff commented that this was another example of the trust not providing feedback following workers speaking up.

We asked trust leaders why they had not shared the lessons learned in the review and had only disclosed its contents to a very small number of people. A senior leader explained that the trust was committed to transparency, but had delayed sharing the review following legal advice that it should first resolve important issues arising from the cultural review before it could publish it. Moreover, publishing the report before these issues were resolved could compromise that process.

However, although the trust clearly needed to be sensitive about some of the review's contents, including the identity of individuals referred to in it, while it resolved certain issues, there was nevertheless significant learning relating to speaking up that the trust could potentially share, without compromising its resolution of those specific issues. These included the majority of the recommendations made by the review's author.

Moreover, the trust's decision to delay sharing any of the learning in the cultural review caused some staff to believe that it was simply repeating historic failures to provide feedback to workers who had spoken up.

Recommendation 15

Within three months the trust should seek to share the learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals.

Fit and Proper Person review

Under section 5 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 service providers, including NHS trusts, are legally required to ensure that each of their directors is a fit and proper person to perform that role and as such that they meet specific standards of competence and character.

In response to workers' repeated concerns about the alleged discriminatory behaviour of one of the trust's directors the trust commissioned an external Fit and Proper Person (FPP) review in 2015 to determine whether the director's competence and character met those standards.

However, evidence cited in the trust's cultural review highlighted that the FPP investigation did not interview any of the staff who had spoken up about the director in question. This was despite the fact that, for a director to be a fit and proper person under the regulations, one of the requirements their employer must show is that they have 'not been responsible for … any serious misconduct or mismanagement' – the very type of misconduct that staff who spoke up were alleging.

Upon completion the FPP review 'found no evidence of discrimination or racial discrimination' against the director in question.

The good practice set out in the Francis Freedom to Speak Up review principles applies to all aspects of the work of NHS trusts, including how they conduct a FPP review. According to good practice, as well as the trust's speaking up policy, concerns raised by workers should be properly investigated. Therefore, the trust's response to its workers' concerns was not in accordance with best practice because its FPP review failed to adequately investigate them.

It is one of the statutory functions of the Care Quality Commission to regulate how services discharge their responsibilities under section 5 of the regulations. Under the regulations a trust must provide the Care Quality Commission with 'satisfactory information' to show that it has discharged its FPP responsibilities. We therefore asked the Care Quality Commission how it assured itself that the trust had satisfactorily conducted its FPP review of its director.

In response, a senior Care Quality Commission inspector said that the commission was satisfied that the trust had gone through due process when completing its FPP review. However, the senior inspector also said that the Care Quality Commission did not have guidelines for inspectors setting out how they determined what information provided by a trust regarding a FPP review would be satisfactory.

However, the senior inspector also acknowledged that 'this was one of the first cases considered by the [Care Quality Commission FPP] panel … [and] there has been a great deal of learning and reflection as our experience has grown and we would now be seeking much greater levels of assurance in similar cases'.

In addition, the senior inspector informed us that the Care Quality Commission had 'been out to consultation around strengthening the [FPP] regulation and … revised guidance will soon be issued. We have undertaken an internal review of our cases and taken external advice from counsel around our approach to FPP investigations all of which has been implemented into practice.'

We commend that the Care Quality Commission has undertaken this work to revise its approach to FPP tests and recommend that the revised guidance it produces for trusts specifically addresses the need for information provided by people speaking up to be considered when assessing whether a satisfactory FPP review has been carried out.

Recommendation 16

Within 12 months the trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.

Recommendation 17

The Care Quality Commission should, where regulating matters relating to a fit and proper persons test under section 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, continue to develop its approach and include the need for information provided by people who speak up to be considered when assessing whether a satisfactory FPP review has been carried out.

Support for staff during the speaking up process

During our case review we spoke to some members of staff who felt that they had not been properly supported when speaking up.

One aspect of this support identified by the Francis Freedom to Speak Up review was the use of mediation, to resolve issues arising from speaking up, whether at the beginning, during or at the end of the process.

We asked staff who had previously spoken up whether the trust had offered them mediation services. None said that this had been offered and many commented that they would have benefitted from it, particularly where speaking up had led to potential conflict between staff members.

Staff members who expressed a desire for mediation support also included those about whom others had spoken up. Staff involved in this part of the speaking up process explained that it was stressful and challenging to have concerns raised about them and mediation would have helped meet their needs.

We asked trust leaders whether mediation was commonly used to resolve issues between workers arising from speaking up. They said that mediation was available in this situation. However, the workers who said they would have benefitted from its use also said that the trust had told them it was not available.

The trust's updated speaking up policy also made no reference to the use of mediation in the speaking up process.

Recommendation 18

Within 12 months the trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns raised.

Recommendation 19

Within 12 months the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.

4. Vulnerable and minority workers

The Francis Freedom to Speak Up review highlighted that minority staff, including black and minority ethnic (BME) workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in the review also showed that minority staffing groups are more likely to suffer detriment for having spoken up.

In addition to BME workers, the review identified minority working groups as those whose employment was of a temporary or junior nature, such as trainees, volunteers and students, which meant that they were less connected within the trust and often lacked support to speak up.

Concerns raised by black and minority ethnic workers

As part of the case review we looked at how the trust supported black and minority ethnic (BME) staff to speak up because we had received information that many BME doctors had reported to the trust acts of bullying and discrimination against them. The perception of a discriminatory culture in the trust against BME staff was corroborated by the findings of the trust's cultural review.

In addition, the trust's 2016 staff survey reported that 15.8% of its BME staff reported that they had experienced discrimination at work from a manager or team leader in the previous 12 months. Out of 21 NHS trusts in the Cheshire and Merseyside region this was the third worst figure. This compared with 5.1% of white staff reporting discrimination in the trust.

BME staff also expressed their concerns about discrimination to Care Quality Commission inspectors during an inspection of the trust in 2016.

As already discussed, one of the reasons we decided to review the speaking up culture, process and policies at the trust was because we had received information that many BME doctors had previously raised concerns about discriminatory treatment, including the fact that the trust had not appropriately responded to those concerns.

We specifically held staff forums at both the Southport and Ormskirk NHS trust sites for BME workers to hear their experiences of speaking up. The trust promoted these events but, unfortunately, very few BME workers attended the forums.

Although we had hoped to speak to some of the BME doctors who had previously raised concerns none of them attended the forums or approached us in person.

Before beginning our review we asked the trust whether any of the doctors concerned still worked at the trust. In response the trust said that some still worked there. In order to try and reach former workers, as well as to publicise the National Guardian's Office's work, we had announced our case review of the trust on our webpages at the beginning of August. The trust also announced the review on its website at the same time.

Of those who attended the BME forums none said that they had been either the victim of, or had witnessed any discriminatory behaviour towards BME staff. Two also said the trust culture was improving following the appointment of new trust leaders.

Meeting the needs of black and minority ethnic workers

We asked senior trust leaders for details of the steps they intended to take to support black and minority ethnic (BME) staff to speak up, given the concerns described above. Several leaders replied that the trust did have BME staff engagement groups in place, but that hardly any BME staff attended them.

When we asked them what the trust would do to encourage better engagement they said that, once an equality and diversity lead was appointed, they would put measures in place to address this. However, the trust leaders were not able to say when this appointment would happen, or what actions might be taken once the lead was appointed.

Regarding the specific concerns themselves we asked trust leaders what steps they intended to take to address them. In respect of the 2016 NHS staff survey trust leaders said the steps they intended to take were contained within the trust Workforce Race Equality Standard (WRES) action plan for 2016-2017. All trusts must produce an annual WRES report, in accordance with their contractual obligations to NHS England, stating how they will address race and equality issues among their workforce.

Much of this plan stated that the necessary actions would be determined by what was said by the trust's cultural review, but at the time of our case review the trust had only implemented one recommendation from that plan and could not say when it would begin implementing the others.

The trust leaders said that its response to the Care Quality Commission inspection was also the cultural review and the WRES action plan, but again this response was compromised by the fact that they had not begun to implement most of the review's findings.

As described earlier in this report trust leaders explained that they had delayed implementing the cultural review following legal advice it had received. Nevertheless, they could not give a timetable of when they would begin implementing the learning from the review.

Finally, the trust was unable to say when it would appoint an equality and diversity lead to supervise all of this essential work.

Support is available for trusts to meet their WRES objectives from the WRES implementation team at NHS England. Once a trust identifies that they need assistance to support their BME staff, they can request help from the team, who will look at a range of relevant data, including staff surveys and help develop action plans to address these issues.

Recommendation 20

Within six months the trust should take all appropriate steps to address the concerns raised by BME workers in the trust 2016 survey .

Recommendation 21

Within six months the trust should appoint an equality and diversity lead and ensure that position is appropriately resourced.

Recommendation 22

Within 12 months the trust should take action to implement all the recommendations of its cultural review.

Recommendation 23

Within three months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BME workers.

What the National Guardian's Office will do now:

Following publication of this report we will work with interested parties to monitor the trust's implementation of our recommendations.

To do this we have asked the trust to publish an action plan within four weeks of the publication date to state what actions they will take.

Once the trust has published its action plan we will then work with the trust's Freedom to Speak Up Guardian to review the progress of those actions in three, six and 12 months. We will do this by meeting at those intervals with the guardian, taking advice from NHS Improvement, Care Quality Commission, and other regulators and experts as appropriate.

Where a review identifies that the trust has not completed the actions in its own plan we will notify regulators to address this.

In addition, we will respond to all those individuals who have spoken to us, thanking them and providing feedback to them on how their experiences have been reflected in this report. We will also ask them for feedback on their experience of how we have conducted this review.

Finally, as part of our 12 month case review pilot, we will reflect upon all the feedback we receive from this and other reviews to help us develop a process that meets the needs of all those the case review programme is intended to support.

We welcome feedback from all readers of this report. Please send your comments to: casereviews@nationalguardianoffice.org.uk

Annex A – summary of recommendations

The recommendations arising from the case review for the trust are listed below.

They are grouped according to when we recommend the trust completes the work to implement each recommendation. The recommendation for the Care Quality Commission is listed separately.

1. Recommendations for the trust

Recommendations to be implemented within three months

Recommendation 1

The trust should publish its new speaking up policy.

Recommendation 4

Within three months the trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.

Recommendation 7

Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.

Recommendation 8

The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.

Recommendation 9

The trust should ensure that it responds to all concerns raised by its workers in relation to the recruitment of staff strictly in accordance with its policies and procedures and in accordance with good practice.

Recommendation 11

The trust should ensure that appropriate steps are taken to publicise the role of guardian and any staff supporting that role, using methods that reach all workers.

Recommendation 12

The trust should ensure that it provides appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the National Guardian's Office, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts.

Recommendation 13

The trust should take appropriate steps to ensure that minority and vulnerable workers, including black and minority ethnic workers are free to speak up.

Recommendation 15

The trust should seek to share the learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals.

Recommendation 23

Within three months the trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its black and minority ethnic workers.

Recommendations to be implemented within six months

Recommendation 2

The trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.

Recommendation 5

The trust should put in place effective systems to monitor the development of a positive speaking up culture.

Recommendation 14

Within six months the should trust look again at its appointment process for the role of Freedom to Speak Up Guardian and ensure a Guardian is appointed using a process that is open and fair.

Recommendation 17

Within six months the Care Quality Commission should, where regulating matters relating to a fit and proper persons test under section 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, take appropriate steps to assure itself that those tests are conducted in accordance that regulation.

Recommendation 20

The trust should take all appropriate steps to address the concerns raised by black and minority ethnic workers in the trust 2016 survey.

Recommendation 21

The trust should appoint a senior member of staff as equality and diversity lead and ensure that position is appropriately resourced.

Recommendations to be implemented within 12 months

Recommendation 3

The trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates.

Recommendation 6

The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.

Recommendation 10

Within 12 months the trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.

Recommendation 16

The trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.

Recommendation 18

The trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns raised.

Recommendation 19

The trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up.

Recommendation 22

The trust should implement all the recommendations of its cultural review.

2. Recommendations for the Care Quality Commission

Recommendation 17

The Care Quality Commission should, where regulating matters relating to a fit and proper persons test under section 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, continue to develop its approach and include the need for information provided by people who speak up to be considered when assessing whether a satisfactory fit and proper person review has been carried out.