Cover page	
Meeting	Trust Board
Paper Title	**Comparison Report and Recommendations From the Royal Cornwall Case Review** The Trust Board are asked to note and discuss the recommendations in the comparison report of the Royal Cornwall Case Review
Date of meeting	3rd October 2019
Date paper was written	May 2019
Responsible Director	Dr Arne Rose, Medical Director and Executive Lead for FTSU
Author	Kate Adney, Freedom to Speak Up Guardian

Executive Summary

In December 2018 the National Guardian Office conducted a review of the speaking up processes, policies and culture at Royal Cornwall Hospital NHS Trust in response to information the office received that the Trust's response to the concerns was not in accordance with good practice.
As stated in the Royal Cornwall Review:

In response to **'other Trusts' responsibilities to implement our recommendations**
'We expect all other NHS Trust Boards in England, in accordance with the guidance we have in collaboration with NHS Improvement, to implement this reports recommendations in their own services, where it is appropriate to do so'

Kate Adney, Freedom to Speak Up Guardian at SaTH has undertaken a review of the recommendations in the Royal Cornwall Case Review and identified the recommendations that as a Trust we might not be meeting.

Of the 13 recommendations in the Royal Cornwall Report there are 4 that have been reviewed in this report with recommendations made. These are:

2. Speaking up Culture – (recommendation 4 in the Royal Cornwall Case Review)
3. Issues raised by workers not handled with suitable independence – (recommendation 5 in Case Review)
5. Failure to respond to speaking up -(recommendation 7 in the Royal Case Review)
2a. Measuring the effectiveness of speaking up – (recommendation 11 in the Royal Case Review)

It is requested that these recommendations are considered and approved at Quality & Safety Committee in order that this paper can be taken to Trust Board to then implement the recommendations in our own service where it is appropriate to do so.

Appendix 1. Royal Cornwall Case Review Paper for Reference

Previously considered by	Quality & Safety Committee September 18th September 2019

The Board is asked to:			
☑ Approve	☐ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☐ Effective	☑ Caring	☑ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	*No*

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*No*

The Shrewsbury and Telford Hospital NHS Trust

Freedom to speak up

Comparison Report and Recommendations From the Royal Cornwall Case Review

Introduction

In December 2018 the National Guardian Office conducted a review of the speaking up processes, policies and culture at Royal Cornwall Hospital NHS Trust in response to information the office received that the Trust's response to the concerns was not in accordance with good practice.
As stated in the Royal Cornwall Review:

In response to **'other Trusts' responsibilities to implement our recommendations**
'We expect all other NHS Trust Boards in England, in accordance with the guidance we have in collaboration with NHS Improvement, to implement this reports recommendations in their own services, where it is appropriate to do so'

The Freedom to Speak Up Guardian at SaTH has undertaken a review of the recommendations in the Royal Cornwall Case Review and identified the recommendations that as a Trust we might not be meeting.
Of the 13 recommendations in the Royal Cornwall Report it has been identified that there are there are 4 that require further action from the Trust.

These are:

2. Speaking up Culture – (recommendation 4 in the Royal Cornwall Case Review)

3. Issues raised by workers not handled with suitable independence – (recommendation 5 in Case Review)

5. Failure to respond to speaking up -(recommendation 7 in the Royal Case Review)

Kate Adney April 2019 v3

2a. Measuring the effectiveness of speaking up – (recommendation 11 in the Royal Case Review)

Comparison review and recommendations

2. Speaking up Culture
It has been reported to the FTSU Guardians that colleagues have been told not to raise concerns via incident reporting and when they have raised concerns these have not be acted upon in an appropriate or timely manner. Incident reporting is not always encouraged and there is a strong belief by colleagues that if they do incident report, nothing is acted upon and there is no feedback given. Incident reporting is thought not to be taken seriously unless there is an element of severe or moderate harm. In fact, incident reporting should be encouraged and acted upon. Feedback when requested should always be adhered to and delivered in a timely manner.
As a Trust we should follow correct procedures when colleagues do speak up to ensure they do not encounter repercussions for speaking up and that a fair process is followed. It should be encouraged to resolve issues in an informal manner prior to entering a formal grievance process. Incident Reporting is currently being reviewed by the Associate Director for Patient Safety, the lower level incidents to identify themes. There are now additional HR colleagues who review staff to staff related incidents that are reported through Datix so these are picked up accordingly and escalated/fedback.

Recommendation
Within 6 months the Trust should review incident reporting rates and identify any areas which appear to be under reporting and address this. From checks made on incidents reported, the level of response to these incidents is inadequate and particularly in relation to staffing issues.

This needs to be acknowledged and fed back to those that have raised their concerns. These are patient safety issues even though there has not been an incident of actual harm to a patient.

3. Issues raised by workers not handled with suitable independence
When a colleague raises a concern it should be taken into account the most appropriate way for this concern to be handled. Avenues should be explored that will ensure the best outcome. Over the last 12 months the number of investigations has been reduced through the HR team challenging whether the investigations is needed and looking at alternative ways to resolve matters.

Some Investigations have historically taken in excess of six months. This could cause detriment to the parties that are being investigated when if there is no case to answer, it would be much harder for an effective return to work. When concerns are raised about behaviours of

colleagues options should be available that does not necessarily involve a formal HR route. This could be a facilitated meeting or mediation.
When a formal investigation is required, there is a delay in finding a suitable Investigating Officers. As a Trust, we do not have a designated Investigation Team within our HR function. Recognising the need, the HR team have implemented Investigating officer training which is delivered in house by the HR team through a classroom based programme with additional podcast resources. There are plans in place to launch commissioning officer training and chair of hearing training.

Recommendation
Within three months the Trust should have suitably trained Investigating Officers to ensure that its response to colleagues speaking up, including the investigations of those issues and the implementation of learning from resulting from them, is undertaken by suitably trained investigators.
Within three months to review the investigation process to ensure that it is fair, impartial and investigations are carried out in a timely manner.
Within three months to launch the Trusts journey to putting people first project, led by the HR team.

5. Failure to respond to speaking up
When colleagues speak up, they should be thanked for speaking up and then their concerns should be looked into in a timely manner, with feedback, as per the FTSU Policy which was updated in April 2019. Concerns that are raised to the FTSU Guardian should be acknowledged within three working days and this is current good practice.
There is a good practice process and Freedom to Speak Up Policy for colleague to refer to when they speak up, whether it to their line manager, through incident reporting or alternative routes. There is inconsistency in how this process is followed and there is evidence that there is not a consistent approach to responding to those colleagues that have raised concerns.
Incident reporting feedback is poor. Colleagues that raise concerns through incident reporting and have requested feedback should be responded to in a timely manner with acknowledgement, evidence that action has taken place and also evidence of learning.
There is evidence where colleagues have incident reported that there has been an unsafe working environment and that it would be unsafe for this to continue. They have requested feedback and this has not been provided. This also causes anxiety for colleagues that have raised concerns and wonder whether their incident report has even be taken seriously or noted.
There is evidence where colleagues have put in an incident report about the same issues on multiple occasions and they have been told that they are incident reporting too much and should in fact speak to their line manager first. Incident reporting should always be encouraged.
As a Trust we have stated that we are committed to listening to our staff, learning lessons and improving patient care and that we encourage and support staff to speak up. That is not evident at present. One colleague said that they had put in eight incident reports on the same issue and has requested feedback and has never heard back.

Recommendation
Within six months the Trust should ensure that it responds to the issues raised by colleagues strictly in accordance with our Trust Values, Policies and Procedures and in accordance with good practice. This should be in a timely manner and feedback should always be provided when a colleague has requested.
Expectations should be made clear when a colleague raises a concern. If this is of a behavioural issue it should be clear at the outset what action will be taken, by whom and when. Updates and feedback should be given at agreed times to ensure that all parties are happy with the progress and actions that are being taken.

2.a Measuring the effectiveness of speaking up
It is important that we are able to measure the effectiveness of speaking up and show that as a Trust we are encouraging staff to speak up and promote a culture of openness. We have recruited a network of FTSU Advocates who will raise the profile of the FTSU Guardians and encourage a culture of openness and for speaking up. To have regular sessions in care groups where FTSU Guardians and Advocates are available to listen to staff and raise any concerns and feedback accordingly. FTSU Guardians to obtain feedback from those that do raise to concerns to ask if they feel that they would raise a concern in the future if they felt they needed to.

We have added some questions in to our Staff Survey that there are specific questions about the effectiveness of speaking up and the Freedom to Speak Up Guardian roles.
The questions that have been added into the staff survey are:

1. Do you know how to raise a concern through he speak up Guardians?
2. To what extent do you agree with the following statement? I feel confident to raise a concern through the Freedom to Speak Up Guardian?
3. Are you aware of the Freedom to Speak Up Policy?

We evaluate the data that is collated by the FTSU Guardians on a quarterly basis and this is reported to the National Guardian Office, Workforce Committee, Quality and Safety Committee and at Trust Board every six months.

Recommendation
At Committee meetings and Trust Board to share evidence of learning, and specific data that has been captured around whether staff feel they are able to speak up. To share at Trust Board the results from the three additional staff survey results that are specific to speaking up.
To share case studies through a range of communication means as evidence that our Trust is promoting a culture of speaking up and its effectiveness. It is also recommended that feedback is gathered through the use of Pulse Survey's.