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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014
XX COMMONWEALTH GAMES
SCOTLAND

All NHSScotland Health Board
Chairs
Chief Executives

Copied to:
HR Directors
Employee Directors

30 June 2015

Scottish Government response to the Freedom to Speak Up Review

As you may be aware, I recently announced the actions the Scottish Government will take in response to the report and recommendations from the Freedom to Speak Up Review, which was chaired by Sir Robert Francis QC, and published on 11 February 2015.

As part of this response, I undertook to write to the Chairs and Chief Executives of all NHSScotland Health Boards to draw attention to relevant local actions identified within the Report. I have attached a full list of the Report's actions in the Annex to this letter and ask that you consider how those relevant to Boards may be implemented locally, if this is not already the case. I recognise that many of the recommended actions relate to the structures in NHS England. However, I would ask that you consider the actions within the context of the structures of the NHS in Scotland, and provide my officials with an update later in the year.

In response to the report and recommendations more broadly, I have committed to:

- The development and establishment of an Independent National Whistleblowing Officer (INO), to provide external review on the handling of whistleblowing cases. Detailed proposals on this role are currently being developed and will be subject to consultation in the Autumn.

- Non-executive "whistleblowing" champions being introduced in each NHSScotland Board. This role has been developed in partnership and is intended to act predominantly as an oversight and assurance mechanism, as well as a conduit to ensure that internal mechanisms are working effectively to support whistleblowing arrangements and staff in raising concerns. The development of this role has been progressed by a partnership working group. It is at an advanced stage, and I will be writing to you again shortly with further details and to invite you to confirm who will undertake this role within your Board.

- Providing further national whistleblowing training events for designated policy contacts within Boards, with a view to roll out locally.

- Write to Healthcare Improvement Scotland (HIS), as the relevant scrutiny body in NHSScotland, to ask it to consider and feedback on how the Report's recommendations on scrutiny may be implemented.

I remain clear that it is vitally important that NHSScotland workers are confident that they can raise any concerns they may have about patient safety and malpractice because it helps to improve our health service. Our continued aim is to create an open and honest culture across NHSScotland where all staff have the confidence to speak up without fear, and with the knowledge that any genuine concern will be treated seriously and investigated properly.

Shona Robison

Please see below a full list of the actions identified within the Freedom to Speak Up Report. Local actions have been marked with an *

***1.1** Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

1.2 System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led.

***2.1** Every NHS organisation should have an integrated policy and a common procedure for employees to formally report incidents or raise concerns. In formulating that policy and procedure organisations should have regard to the descriptions of good practice in this report.

***2.2** NHS England, NHS TDA and Monitor should produce a standard integrated policy and procedure for reporting incidents and raising concerns to support Action 2.1.

***3.1** Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.

3.2 Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well led.

***3.3** Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.

***4.1** Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.

***5.1** Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.

***6.1** All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.

***7.1** Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.

***7.2** All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.

***8.1** All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.

***9.1** All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to:

- address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern
- repair trust and build constructive relationships.

***10.1** Every NHS organisation should provide training which complies with national standards, based on a curriculum devised jointly by HEE and NHS England in consultation with stakeholders. This should be in accordance with the good practice set out in this report.

***11.1** The Boards of all NHS organisations should ensure that their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including:

a) a person (a 'Freedom to Speak Up Guardian') appointed by the organisation's chief executive to act in a genuinely independent capacity;

b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board;

c) at least one nominated executive director to receive and handle concerns;

d) at least one nominated manager in each department to receive reports of concerns;

e) a nominated independent external organisation (such as the Whistleblowing Helpline) whom staff can approach for advice and support.

***11.2** All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern.

11.3 NHS England, NHS TDA and Monitor should issue joint guidance setting out the support required for staff who have raised a concern and others involved.

12.1 NHS England, NHS TDA and Monitor should jointly devise and establish a support scheme for NHS workers and former NHS workers whose performance is sound who can demonstrate that they are having difficulty finding employment in the NHS as result of having made protected disclosures.

***12.2** All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.

***13.1** All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

***13.2** All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.

***13.3** a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.

b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.

c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.

d) NHS TDA and Monitor should consider whether their role of reviewing such agreements should be delegated to the Independent National Officer recommended under Principle 15.

***14.1** Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.

14.2 Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.

***14.3** All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation

15.1 CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post of an Independent National Officer (INO) might jointly be created and resourced and submit proposals to the Secretary of State as to how it might carry out these functions in respect of existing and future concerns.

16.1 CQC, Monitor, NHS TDA in consultation with the Department of Health should work together to agree procedures and define the roles to be played by each in protecting workers who raise concerns in relation to regulated activity. Where necessary they should seek amendment of the regulations to enable this to happen.

16.2 Healthcare professional regulators should review their procedures and processes to ensure compliance with the good practice set out in this report and with this Principle.

17.1 CQC should consider the good practice set out in this report when assessing how organisations handle staff concerns. Good practice should be viewed as a positive factor contributing to a good or outstanding rating as part of their well-led domain.

18.1 Professional regulators and Royal Colleges, in conjunction with Health Education England should ensure that all students and trainees working towards a career in healthcare have access to policies, procedure and support compatible with the Principles and good practice in this report.

***18.2** All training for students and trainees working towards a career in healthcare should include training on raising and handling concerns.

19.1 NHS England should include in its contractual terms for general/primary medical services standards for empowering and protecting staff to enable them to raise concerns freely, consistent with these Principles.

19.2 NHS England and all commissioned primary care services should ensure that each has a policy and procedures consistent with these Principles which identify appropriate external points of referral which are easily accessible for all primary care staff for support and to register a concern, in accordance with this report.

19.3 In regulating registered primary care services CQC should have regard to these Principles and the extent to which services comply with them.

20.1 The Government should, having regard to the material contained in this report, again review the protection afforded to those who make protected disclosures, with a view to including

discrimination in recruitment by employers (other than those to whom the disclosure relates) on grounds of having made that disclosure as a breach of either the Employment Rights Act 1996 or the Equality Act 2010.

20.2 The list of persons prescribed under the Employment Rights Act should be extended to include all relevant national oversight, commissioning, scrutiny and training bodies including NHS Protect, NHS England, NHS Clinical Commissioning Groups, Public Health England, Healthwatch England, local Healthwatch, Health Education England, Local Education and Training Boards and the Parliamentry and Health Services Ombudsman.

20.3 The Government should ensure that its proposal to widen the scope of the protection under the Employment Rights Act 1996 includes all students working towards a career in healthcare.