Draft press statement

Last year I was asked by the Secretary of State to chair the Freedom to Speak Up review, an independent review on creating an open and honest reporting culture in the NHS.

When I began my work, I had an open mind about what I might find. What I heard during the course of the review, from staff, employers, regulators, unions and others, leaves me in no doubt that there is a serious problem in the NHS. Safety is the most important thing NHS patients expect. While we all accept that sometimes even the best medical care cannot cure us, it is difficult to accept avoidable harm from the service to which we have turned for help. If, as this Review has shown, safety issues known to staff are not always being addressed, then patient safety will be at risk.

It is just as important to protect the integrity of the service. If it loses money because of dishonestly or incompetence, or misleading information is given out, our trust in the NHS is diminished. If, as the evidence suggests can happen, staff do not feel free to speak up about such matters our trust in the NHS will be diminished.

The interest and commitment from all parts of the NHS has been impressive and widespread. I received over 600 contributions from people with experiences and views they wanted to share. Over 19,500 completed an independent online survey. I met over 300 personal contributors and representatives of organisations in individual, group meetings and seminars. I want to thank everyone who came forward to contribute to the review – every contribution was taken into account. I recognise for some it was very difficult to relive their experiences.

I have heard loud and clear that NHS staff from all levels of the service want to do the right thing and that their leaders, representatives and employers want to support them to do it. Staff want to speak up, and even though it can be challenging to voice their concerns, many of them do just that day in, day out. Incidents are reported, issues are discussed, and action is taken.

So we need to remember: everyone working in the NHS can be a whistleblower.

It is the dedicated people working for the NHS who are best able to point out issues and concerns that might compromise the safety of

patient care or undermine the integrity of the NHS. Every time they speak up we should thank them for it, because above all we want to feel safe when being cared for by the NHS.

Unfortunately there are some places where too many staff are afraid – afraid that if they raise difficult or contentious issues they will not be listened to, nothing will happen, or, worse, that they will be bullied or have the finger of blame pointed at them. Too many of them have seen colleagues suffer for trying to raise honest concerns, and inaction when action is desperately needed. Too often honestly expressed anxieties are met with hostility, and a breakdown of working relationships. Worse still, sometimes people suffer life changing events – they lose their jobs, their careers, even their health. In the words of one contributor to the review:

> *'My experience has been horrific, protracted, and detrimental to my family life, health and professional standing.'*

The numbers who suffer in this way may be small, but for every one of them many others are deterred from speaking up, and we are all the worse off as a result.

Sometimes no one looks properly at what worried them in the first place. Then patients are left at risk, poor practice goes uncorrected, and lessons are not learnt.

There has been much progress since the awful events uncovered in the Mid Staffordshire inquiries to bring about an open, honest and transparent culture in the NHS. We are working towards better ways of ensuring that patients are listened to when they complain, that when things go wrong there is candour and lessons are learnt, and that we have better methods of understanding how well our hospitals and other services are performing. The priority to be given to safety, compassion, and quality of care is better recognised and acted on. This is a tribute to a great deal of hard work by people throughout the system, and we are now beginning to see the tangible results for patients from these changes.

In spite of this progress, the contributions of the many individuals and organisations to this Review convince me that more needs to be done to ensure that the NHS truly values the knowledge, commitment and energy possessed by its staff, so that no one need be afraid of raising

honestly held concerns, and that when they do the concerns are investigated properly and appropriate action is taken.

There is no doubt that even in the best run organisations raising an issue can be difficult and require sensitivity, both in how the concern is expressed and how it is received.

My review also brought home to me how challenging it can be to receive concerns – issues can be difficult and sensitive to solve. The impact of raising concerns is not limited to the person who speaks up; teams, colleagues and the person who is the subject of any issue raised can also suffer personally and professionally. As one contributor told the Review

> *'cases are often not straightforward and can involve complex and long-standing professional and interpersonal difficulties between clinical colleagues. Cases can become a toxic mixture of grievance and disciplinary action where positions between quickly entrenched.'*

While there may be some whistleblowers who have suspect motives, the safety issues they raise may be genuine, and until the facts are established protecting patients and the public has to be the first priority. The problem comes when there is disagreement about the concern that has been raised. If patient safety is our number one priority, we simply cannot afford to attack the messenger and question their motives, rather than focusing on the issue, not the person, and establishing the facts, quickly and independently.

Taking into account all the evidence obtained by the Review, I have reached the conclusion that there must be a change of culture. No amount of legal or regulatory change will make it easier for staff to raise issues that worry them unless there is a culture which encourages and supports them to do so.

We need to establish everywhere a culture in which:

- all staff feel safe to raise their concerns
- speaking up about what worries them is a normal part of everyone's routine
- if they do speak up they are free from the fear that they will be bullied and badly treated
- leaders at all levels demonstrate through their own behaviour that they welcome and encourage the raising of concerns

- all staff have regular and adequate opportunities to reflect together on how they improve the way they do their work and learn from their joint experiences
- all staff have regular and effective training in raising and handling concerns.

Everyone knows that culture change is not easy. What I have aimed for in my report is to set out some steps I believe will help bring this about – principles for all to follow and practical actions to put safety at the centre of NHS culture, to make raising concerns the normal thing to do, ensuring leaders are visible and bullying is not tolerated.

Organisations should make it as easy and normal for staff to raise matters that worry them as it is to report incidents; there need to be more varied ways available to do this. Managers need to be better equipped to deal with issues that can be difficult to solve; they need to have the resources for fair, proportionate, and blame free investigations to establish facts promptly and to identify remedial action. We need better ways of protecting staff from bullying and other unfair treatment when they have done the right thing. Staff and managers all need access to the right training and support.

To put this into action I propose a variety of measures with the first priority of bringing about cultural change – making raising concerns the normal thing to do, giving more time for reflective practice and learning, leaders acting as they speak and decisive action to prevent bullying; new support to make the system work well and a means of redress where things are going wrong. My proposals include:

- an overhaul of policies so that they don't stand in the way of people raising concerns with those who can take action about them
- training for all NHS staff so they know how to raise their concerns and how to handle and act on them
- a Freedom to Speak Up Guardian for every NHS employer – a named person who is trusted by staff and by their leaders to listen, to advise and to facilitate getting the information to the right place to ensure that appropriate action is taken
- an Independent National Officer who can support the local Guardians, advise on action where cases are going wrong, who knows how to unblock investigations that are not focusing on

patient safety issues properly, and where there is injustice, can ensure something is done to correct it by those responsible for doing so

- a support scheme for good NHS staff who have difficulty in finding work after raising concerns
- a review of the law to prevent discrimination against people who have been brave enough to speak up and help them get back into work.

To make sure this happens we need a coordinated approach from commissioners, oversight bodies, regulators and employers that promotes the right culture and ensures accountability for any mistreatment of staff raising concerns.

I believe that taken together, I believe these measures will make the NHS a place:

- where there is a culture in which staff feel encouraged and safe to speak up – one where it is the normal thing to do
- in which all concerns are heard and investigated properly, with the right support on hand for staff, managers and others involved in the concerns raised
- where those who have been brave enough to speak up are celebrated and organisations who get it right are recognised
- that supports good NHS staff who have suffered as a result of speaking up, to get back into work or to develop new skills
- where all staff, but in particular vulnerable groups, such as student nurses and medical trainees, are protected from intimidation.

Most of these measures can be implemented by trusts now. Many of the steps I recommend are what good organisations are already doing. If these things are achieved, the NHS will be a better place to work. Most importantly, it will be a safer place for patients – a place in which avoidable harm is much less likely to occur.