Freedom to **speak up**

An independent review into creating an open and honest reporting culture in the NHS

Executive Summary

February 2015

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Introduction

1 This Review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up. In recent years there have been exposures of substandard, and sometimes unsafe, patient care and treatment. Common to many of them has been a lack of awareness by an organisation's leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did. The 2013 NHS staff survey showed that only 72% of respondents were confident that it is safe to raise a concern. There are disturbing reports of what happens to those who do raise concerns. Yet failure to speak up can cost lives.

2 The aim of the Review was to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. The Review is not the Public Inquiry that some have demanded, and it has not been tasked with investigating or passing judgment on individual cases. Its purpose has been to draw lessons from the experiences of those involved in raising and handling concerns. It has been important to hear these experiences, good and bad, to achieve this.

3 The message from staff who have suffered as a result of raising concerns has been loud and clear. I heard shocking accounts of the way some people have been treated when they have been brave enough to speak up. I witnessed at first hand their distress and the strain on them and, in some cases, their families. I heard about the pressures it can place on other members of a team, on managers, and in some cases the person about whom a concern is raised. Though rare, I was told of suicidal thoughts and even suicide attempts. The genuine pain and distress felt by contributors in having to relive their experiences was every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries. The public owe them a debt of gratitude in the first place for speaking up about their concerns, and secondly for having the courage to contribute to this Review.

4 The experiences shared with us, and the suffering caused by them, have no place in a service which values, as the NHS must, its workforce and the profound contribution they make to patient safety and care. The NHS has a moral obligation to support and encourage staff to speak out.

5 I also heard it suggested that some people raise concerns for dubious motives, such as avoiding legitimate action to address poor performance. It was not within the remit of the Review to pass judgment on whether any of the cases we heard fell into this category. To the extent that this happens, it is highly regrettable, not least because it taints some people's view of whistleblowers and makes it harder for the many NHS staff who raise genuine concerns. Whatever the motive, the patient safety concerns they raise may still be valid and need to be addressed as well the performance issue. It is clear to me that in too many cases this is not done. Suggestions of ulterior purposes have for too long been used as an excuse for avoiding a rigorous examination of safety and other public interest concerns raised by NHS staff.

6 I recognise that cases are not always clear-cut. We heard contradictory accounts of some cases from those with different perspectives. There is nevertheless a remarkable consistency in the pattern of reactions described by staff who told of bad experiences. Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised. Whilst there may be some cases in which issues are fabricated or raised to forestall some form of justifiable action against them, this cannot be true of them all. I have concluded that there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them.

7 There are many reasons why people may feel reluctant to speak up in any industry. For example, they may be concerned they will be seen as disloyal, a 'snitch' or a troublemaker. Two particular factors stood out from the evidence we gathered: fear of the repercussions that speaking up would have for an individual and for their career; and the futility of raising a concern because nothing would be done about it.

8 The NHS is not alone in facing the challenge of how to encourage an open and honest reporting culture. It is however unique in a number of ways. It has a very high public and political profile. It is immensely complex. It is heavily regulated, and whilst the system consists of many theoretically autonomous decision-making units, the NHS as a whole can in effect act as a monopoly when it comes to excluding staff from employment. Further, the political significance of almost everything the system does means that there is often intense pressure to emphasise the positive achievements of the service, sometimes at the expense of admitting its problems.

9 Speaking up is essential in any sector where safety is an issue. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish. There needs to be a more consistent approach across the NHS, and a coordinated drive to create the right culture.

Background: legal and policy context

10 This Review took place in a complex and changing climate. The legal and policy framework surrounding whistleblowing is not easy to understand and has many layers. The detail of the law for the protection of whistleblowers has been amended frequently and recently. There is a range of other reviews, as well as measures and initiatives at both local and national level that will directly or indirectly have an impact on the ease with which NHS workers can speak up. This shows recognition of the issues described in this report, and the need for action to address them. However it is important that these measures are brought together. I have attempted to take account of them in the Principles and Actions, but it will be important that those charged with their implementation place them appropriately in the context.

Legal context

11 In brief, the legislation which theoretically provides protection for whistleblowers is contained in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998, commonly known as PIDA. Where a worker makes a protected disclosure, he/she has a right not to be subjected to any detriment by his employer for making that disclosure.

12 For a number of reasons this legislation is limited in its effectiveness. At best the legislation provides a series of remedies after detriment, including loss of employment, has been suffered. Even these are hard to achieve, and too often by the time a remedy is obtained it is too late to be meaningful.

13 The legislation does nothing to remove the confusion that exists around the term 'whistleblowing', which does not appear in it at all. It was clear from the written contributions and meetings that the term means different things to different people or organisations. It is sometimes taken to imply some sort of escalation: someone 'raises a concern', then 'blows the whistle' when they are not heard, either within the organisation or to an outside body. Yet this is not how the law defines a protected disclosure.

14 The legislation is also limited in its applicability. It applies only to 'workers' as defined by PIDA, so provides no protection against, for example, discrimination in recruitment, and is only now being extended to include student nurses.

Recent changes and initiatives

15 In recent years there has been a range of measures which may encourage, or impose a responsibility on staff to speak up. These include introduction of a new Statutory Duty of Candour,

the Fit and Proper Person Test and Care Quality Commission's (CQC) new inspection and ratings regime. At both national and local level there have been initiatives and programmes to encourage and support staff to speak up. A range of advice and support is also available to support individuals via helplines or websites. I concluded that it is too early to assess the combined impact of these initiatives, but that they all help to reinforce the message that speaking up is integral to patient safety and care.

Evidence to the Review

16 It was important to me to hear from as many people who had direct experience of raising and receiving concerns as possible. Over 600 individuals and 43 organisations wrote in response to our invitation to contribute and over 19,500 responded to the staff surveys sent out by independent researchers. We met with over 300 people through meetings, workshops and seminars. This included individuals who had raised concerns, student nurses, trainee doctors, and representatives from professional and regulatory bodies, employers, trades unions, lawyers, Black and Minority Ethnic (BME) groups and organisations that represent whistleblowers to ensure that I was able to understand the issues from all the different perspectives. We held four seminars in different parts of the country with a cross section of invited delegates to consider different stages of the process of raising concerns and potential solutions. I also commissioned independent qualitative and quantitative research.

Experience of employees

17 The vast majority of people who took the time to write to the Review reported bad experiences. Many described a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation. Bullying and oppressive behaviour was mentioned frequently, both as a subject for a concern and as a consequence of speaking up. They also spoke of lack of support and lack of confidence in the process.

18 Despite the efforts to improve the climate described in paragraph 15, many of the contributions described cases that are recent or current. This indicates that there is still a real problem. From the evidence it was apparent that there are problems at a number of stages including deterrents to speaking up in the first place, poor handling of concerns that are raised, and vindictive treatment of the person raising the concerns. This can have a devastating impact on the person who spoke up, including loss of employment and personal and family breakdown.

Vulnerable groups

19 It was also clear from the evidence that there are some groups who, for different reasons, are particularly vulnerable including locums and agency staff, students and trainees, BME groups and staff working in primary care.

Experience of employers in receiving and handling public interest concerns

20 The independent research identified two distinct cultures within organisations. Some took a strict procedural approach when concerns are raised; others took a more open minded, less rigid approach which focused on resolving the issue, learning and communicating rather than following procedure. The researchers concluded that the latter were still at a formative stage and that even where there was a willingness to be more flexible, organisations were not entirely sure how to achieve it.

21 Employers who receive public interest disclosures have reported varied experiences. While all accept that many disclosures are made in good faith, they were concerned that some disclosures are made in order to pre-empt or protect the person raising them from performance action or disciplinary processes they face for entirely unrelated issues. The problems employers described included separating safety and other concerns from grievance and disciplinary issues, identifying means of addressing relationship issues, and the need to distinguish between culpability and responsibility.

Experience of colleagues

22 Concerns about patient safety can have implications for clinical colleagues and managers. An incident or a series of incidents may be attributable to poor performance by an individual clinician or a team. It may be suggested that there is a systemic cause for the concern, such as a staff or equipment shortage for which one or more level of management may be considered responsible. In cultures where blame is an accepted method of explaining a concern, those implicated by a concern are likely to react in a defensive manner. Working relationships with colleagues may suffer, and organisations may default to hierarchical solutions.

The role of regulators and other external bodies

23 Organisations such as regulators and oversight authorities also face issues when approached by workers raising concerns, such as difficulty establishing the facts where reports are made anonymously, or protecting confidentiality. There may also be challenges in distinguishing between appropriately reported cases and referrals which are in retaliation against someone who has raised a concern.

The role of legal advisors

24 When asked for advice by NHS organisations about issues around public interest disclosure, legal advisors have tended to be influenced by an adversarial litigation – and therefore defensive – culture. Lawyers in such circumstances tend to look for potential defences to a claim made under public interest disclosure law, rather than to advise on the positive steps that could be taken to avoid some of the issues described above. Their focus is to pre-empt an Employment Tribunal (ET) claim rather than to assist in the prioritisation of the public interest, or to help resolve a dispute informally by sitting round a table.

Emerging Themes

25 Concerns are raised daily throughout the NHS, and are heard, addressed and resolved. Steps are being taken in some trusts to improve the way in which management responds to concerns. Nevertheless the level of engagement with the Review, the consistency of the stories we heard and the fact that so many of the cases are current or recent convinced me that problems remain and there is an urgent need for system wide action.

26 The evidence presented to this Review is consistent with evidence from other sources. Whilst views may differ about the progress that has been made, there was a remarkable degree of consensus on the need for improvement, the nature of the problems in the system and what a good system would look like. Adopting such a system will benefit not only those who raise concerns, but also patients, management and the wider NHS.

27 From the evidence we drew five overarching themes. These are the need for:

- culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- extending the legal protection.

28 Chapters 5-9 of this report address each of these themes. They set out the Principles which I believe should be followed to bring about the change required, and Actions which follow from each. These are summarised at the end of the Executive Summary. The chapters contain some examples of both good practice that we heard about during the Review. At the end of each section is a summary of what I consider to be good practice in relation to each Principle. This is summarised in Annex A.

Culture

Principle 1 – Culture of safety

Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

29 Culture change is essential, but experience from other sectors where safety is an issue suggests that it takes time and considerable effort by the leadership of an organisation. Boards must devote time and resource to achieving this change. There was support for the concept of a 'just culture' as opposed to a 'no blame' culture. The primary need is to move from a culture which focuses on 'who is to blame?' to one focused on 'has the safety issue been addressed?' and 'what can we learn?'. Without this, senior levels of organisations will remain ignorant of important concerns, some of which give rise to serious safety risks.

30 Progress towards the creation of the right culture should be taken into account by the system regulators in assessing whether an organisation is well-led.

Principle 2 – Culture of raising concerns

Raising concerns should be part of the normal routine business of any well-led NHS organisation.

31 Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their own performance may be the subject of comment, and that this needs to be seen as an opportunity to learn rather than a source of criticism. I appreciate this is not always easy.

32 Policies and procedures for dealing with staff concerns should not distinguish between reporting incidents and making protected disclosures. Our independent research found considerable variation in the quality of policies, and there was agreement that greater standardisation would be helpful given that a proportion of the workforce move between NHS organisations. NHS England, Monitor and the NHS Trust Development Authority (NHS TDA) should produce a standard policy and procedure.

33 To reinforce the concept of raising concerns as a safety issue, responsibility for policy and practice should rest with the executive board member who has responsibility for safety and quality, rather than human resources.

34 Investigation of the concern should be the priority, and any disciplinary action associated with it should not be considered until the facts have been established. This need not delay any performance action that is already underway and unrelated to the concern. It is important that this is well documented to demonstrate that it is not being done in retaliation, to dispel any perception that an individual is being victimised. Poor performance is itself a safety issue, and it is important that it is addressed. The important point here is that managers can show that action taken is justified and is consistent with the way others in the organisation have been treated.

Principle 3 – Culture free from bullying

Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

35 There were more references to bullying in the written contributions than to any other problem. These included staff raising concerns about bullying, or being afraid to do so, bullying of people who had raised concerns and frustration that no-one ever appeared to be held to account for bullying. This is corroborated by the NHS staff survey and by other reports including the

General Medical Council (GMC) National Training Survey[1] and the Royal College of Nursing (RCN) employee survey[2]. Some individual trusts have also acknowledged the existence of a bullying culture and taken steps to address it.

36 Bullying in the NHS cannot be allowed to continue. Quite apart from the unacceptable impact on victims, bullying is a safety issue if it deters people from speaking up. It also has implications for staff morale and for attendance and retention. We heard many examples of unacceptable behaviour and lack of respect by individuals. This has a significant impact on whether people feel able to speak up, particularly in a hierarchical culture such as the NHS.

37 It is important to take a systems approach when bullying occurs, in line with the concept of a just culture. There needs to be an examination of the causes of bullying behaviour. If it is the result of unacceptable demands or pressures on an individual, they should be addressed first. There is also a need for honest and direct feedback to individuals about the impact of their behaviour, and support provided where this might be more productive than admonition. Failure to modify bullying behaviour should always be a matter for disciplinary action.

38 All leaders and managers in NHS organisations must make it clear that bullying and oppressive behaviour is unacceptable and will not be tolerated. Everyone needs to develop self-awareness about their own behaviour and its effect on others. Everyone in leadership and managerial positions should be given regular training on how to address and how to prevent bullying. Regulators should consider the prevalence of bullying in an organisation as a factor in determining whether it is well-led, and 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.

Principle 4 – Culture of visible leadership

All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

39 Visible leadership is essential to the creation of the right culture. Leaders at all levels, but particularly at board level, need to be accessible and to demonstrate through actions as well as words the importance and value they attach to hearing from people at all levels. There is some excellent practice in some trusts, which should be shared and adopted across the NHS.

Principle 5 – Culture of valuing staff

Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

40 Public recognition of the benefits and value of raising concerns sends a clear message that it is safe to speak up, that action will be taken, and that the organisation has the confidence to be transparent and open about things that need to be addressed and wants to hear about them. There was no appetite for financial incentives for individuals, and I do not believe it is either necessary or desirable to offer them.

Principle 6 – Culture of reflective practice

There should be opportunities for all staff to engage in regular reflection of concerns in their work.

41 The Review heard many examples of reflective practice, where issues are explored, systems are analysed and problems or best practice shared. These are invaluable, and should be encouraged throughout the NHS. We also heard that the pressure on the service means that the time available for such practice is being squeezed.

1 *National Training Survey 2014: bullying and undermining*, General Medical Council, November 2014
2 *RCN Employment Survey 2013*, Royal College of Nursing, September 2013

In some cases staff are expected to attend in their own time. I fully recognise the demands and pressures on the system. However these opportunities are essential as a means of sharing information and learning. Just as important, they help to develop a culture of openness and focus on safety not blame, and send a clear signal to staff that this is important.

Handling Cases

42 It was clear in so many of the cases we heard about that if they had been handled well from the outset, a great deal of pain and expense could have been avoided. The more issues can be 'nipped in the bud', the greater the likelihood that there will be a successful outcome for everyone involved. A common factor in many of the cases we heard about was the length of time they took to resolve, if indeed they were ever resolved. Some had gone on so long it was impossible or impracticable to get the full picture. The impact of this on both individuals and organisations was immense.

Principle 7 – Raising and reporting concerns

All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

43 Many concerns are raised every day, and resolved quickly and informally. This should be encouraged wherever possible, provided it is done openly and positively. Where a concern involves a serious issue or incident or where there is disagreement about the seriousness of the concern, there needs to be a more formal mechanism for logging it, processing it and monitoring how it is being handled. This will provide a clear trail for future reference and avoidance of dispute, and also helps to identify trends, common issues and patterns to enhance organisational learning.

44 Any system needs to be as simple and free from bureaucracy as possible. However it needs to provide clarity to the person who has raised a concern about what will happen next and how they will be kept informed of progress. This report sets out what I consider to be the minimum requirements of a system and procedure to ensure that cases are well handled. This was drawn up from the problems that were described in the written contributions and in meetings, and the solutions discussed at the seminars. To ensure it is taken seriously, the Chief Executive Officer (CEO) or a designated board member needs to be involved and should regularly review all concerns that have been logged formally to ensure they are being dealt with appropriately and swiftly.

45 We heard differing views about the desirability of allowing concerns to be raised anonymously, as distinct from in confidence. They can be harder to investigate, and the motive for doing so may be questionable. In an ideal world it would not be necessary to raise concerns anonymously. In the meantime I am persuaded that they have an important role to play and should be treated as formal concerns. I was reassured to find that an anonymous concern sent to several organisations was taken seriously and acted upon.

Principle 8 – Investigations

When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

46 Three clear messages that came from contributors were the importance of establishing the facts, and the importance of doing so quickly, and where necessary independently, and the need to feed back to the individual and share learning more widely. In some other sectors where safety is a critical issue there are teams of independent investigators who move in at once and are quickly able to provide an initial report.

47 Where concerns are raised formally, organisations should arrange for the facts and circumstances to be investigated quickly and with an appropriate level of independence. Where the investigation is done internally, it is essential that those conducting it have the appropriate expertise; that they are genuinely independent; and that they have the training and the time to do so

immediately, and are not trying to fit it in around their normal duties.

48 I am not persuaded that it is necessary to insist that all investigations are undertaken by external investigators. Nor do I consider that it would be appropriate to prescribe timescales for investigating concerns in the NHS, not least because the range of issues and circumstances is so diverse.

49 Feedback to the person who raised the concern is critical. The sense that nothing happens is a major deterrent to speaking up. There are situations where this is not straightforward due to the need to respect the privacy of others involved in the case. However there is almost always some feedback that can be given, and the presumption should be that this is provided unless there are overwhelming reasons for not doing so.

50 Suspensions and special leave should only be used where there is a risk to patient or staff safety, or concern about criminal wrongdoing or tampering with the evidence. If it is necessary to take precautionary measures, efforts should be made to redeploy staff elsewhere on the site or to a non-patient facing role, or to limit their practice. Leaving people on leave or suspension for months on end increases their sense of isolation and the likelihood they will suffer mental health issues which in turn undermine or delay their ability to return to work.

51 There are circumstances where a working environment can become intolerable if someone has, or is believed to have raised a concern which is taken to be critical of colleagues. Ideally the person who spoke up should not be the person who is moved, as this can send a signal that they have done something wrong.

Principle 9 – Mediation and dispute resolution

Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

52 It would be unrealistic to expect a service as complex and pressured as the NHS to run without some professional disagreement or conflict. However poor working relationships can be a risk to patient safety where they impact on communication, morale and willingness to speak up. These need to be addressed, through more proactive management and training in having honest conversations and giving feedback, and through the use of neutral third parties such as a trained mediator.

53 Mediation and dispute resolution techniques can play a role in resolving disputes at a much earlier stage, before positions become entrenched or relationships break down irretrievably. They can be used to rebuild trust within a team after a difficult period. Mediation needs to be done by trained experts and by people who understand the context within which they are operating.

Measures to support good practice

54 Creating the right culture and enabling the effective formal handling of concerns are essential if the ability of NHS staff to raise concerns is to be improved. In addition a number of other measures are needed to support the system to ensure that it works as it should.

Principle 10 – Training

Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

55 For the system to work effectively, there needs to be more training, both for staff in how to raise concerns and for managers in how to receive and handle concerns. Raising concerns, and being

able to accept, with insight and without being defensive, concerns being raised about one's own practice is a fundamental skill that all NHS workers need to have.

56 Training should be provided through face to face sessions which provide insight into others' perspectives: for example how it might feel if an issue is raised which could be interpreted as personal criticism, or how difficult it can be to raise a sensitive issue with someone more senior. Training in multi-disciplinary teams can help to create a shared understanding and common language and to break down silos. More senior members of staff will need additional training in how to handle concerns.

57 Raising concerns and the role of Human Factors[3] should be included in the curriculum of all healthcare professional training programmes. It is important that there is a high level of consistency in the training provided. I therefore invite Health Education England and NHS England, in consultation with stakeholders, to devise a common structure based on the good practice described in this report, to underpin training provided in trusts.

Principle 11 – Support

All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

58 Another recurrent theme from the contributions was the absence of anyone to turn to for support, either before they spoke up, or once they had done so. This added immeasurably to the personal stress they felt. By contrast those who told us that their experience had been good often mentioned that they felt supported throughout.

59 Two things are needed: clarity about to whom concerns can be reported; and clarity about where to go for support. There are various ways this could be provided, and ideally there will be more than one source. Some trusts have nominated a Non-Executive Director (NED) to receive concerns; some allocate a senior person to act as a buddy, or named executive directors, both to receive concerns and to offer advice.

60 Some trusts have established a new role, sometimes known as a 'cultural ambassador' or 'patient safety ombudsman'. Their role is to act as an independent and impartial source of advice to staff, with access to anyone in the organisation, including the CEO, or if necessary outside the organisation. They can ensure that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and issues addressed; and that there are no repercussions for the person who raised it. They can also act as an 'honest broker' to verify that if there were pre-existing performance issues that were already being addressed, these should continue and cannot be portrayed as a consequence of speaking up.

61 I believe such a role can make a huge contribution to developing trust within an organisation and improving the culture and the way cases are handled. I believe there would be merit in having similar roles in all NHS organisations, with a common job title such as Freedom to Speak Up Guardian, so that those who move between organisations know immediately where to go for help. They could also form a network to share good practice and to identify common issues and themes. I strongly encourage all NHS organisations to consider it. I have stopped short of recommending that all must adopt this model, as I believe boards should decide what is appropriate for their organisation. But as a minimum there needs to be someone to whom staff can go, who is recognised as independent and impartial, has the authority to speak to anyone within or outside the trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed, and has dedicated time to perform this role.

62 It was suggested that some may not be comfortable seeking advice from a Freedom to Speak Up Guardian if, for example, they are from a different professional background. There should

3 A definition of Clinical Human Factors is "Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation or human behaviour and abilities, and application of that knowledge in clinical settings." See Clinical Human Factors Group website http://chfg.org/what-is-human-factors

therefore be a range of others to whom people can go for advice and support. This should include at least one executive director, which may be the person responsible for safety and/or the medical director; at least one nominated manager in each department; and one external organisation, such as the Whistleblowing Helpline.

63 Support should also be available in the form of counselling and other psychological support. The evidence seen by the Review indicates that psychological damage is a foreseeable risk of not treating staff correctly when concerns are raised. We heard harrowing accounts from people about anxiety and depression due to the stress and repercussions of raising a concern, and in too many cases counselling appeared to have been promised but never materialised. This is short-sighted as well as uncaring, as it delays the point at which staff are able to return to work, and could conceivably lead to expensive litigation.

Principle 12 – Support to find alternative employment in the NHS

Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

64 A number of people leave their employment, either voluntarily or otherwise, after raising a concern. Some then find it difficult to find another job. The NHS can operate as a monopoly employer in many fields, and a contentious parting of the ways can result in an individual being disadvantaged when applying for a new role, without the full facts of a case being known. This is unfair on individuals, and a waste of valuable skills and resource to the NHS.

65 Where an Employment Tribunal orders reinstatement in a case involving protected disclosures, NHS organisations have a moral responsibility to re-instate the individual if at all possible, if their performance is sound, with appropriate support and development for them and/or for their colleagues to ensure they are re-integrated effectively.

66 Beyond that, there needs to be a support scheme for staff who are having difficulty finding employment and can demonstrate that this is related to having made a protected disclosure, and about whom there are no issues of justifiable and significant concern about their performance. This should be run jointly by NHS England, the NHS TDA and Monitor, and should be supported by all NHS organisations. As a minimum it should provide:

- remedial training or work experience for registered healthcare professionals who have been away from the workplace for long periods of time
- advice and assistance in relation to applications for appropriate employment in the NHS
- the development of a 'pool' of employers prepared to offer trial employment
- guidance to employers to encourage them to consider a history of having raised concerns as a positive characteristic in a potential employee.

Principle 13 – Transparency

All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

67 Lack of transparency and openness creates suspicion and mistrust. It also means that opportunities to share learning and improve patient safety may be lost. Conversely transparency about incidents and concerns, and how the trust has responded to them, sends an important signal to staff that the board welcomes and values them, and provides an opportunity to demonstrate how they focus on finding solutions and taking action, not on apportioning blame.

68 All NHS organisations should publish in their Quality Accounts quantitative and qualitative data about formally reported concerns. This could then be used by the National Learning and Reporting System to identify safety issues that are common across the NHS, and to spread learning and best practice. This requires the NHS system regulators to adopt a common approach to data about concerns, with a shared understanding of what good looks like so that there is no disincentive to trusts to be transparent and open.

69 My attention was also drawn to the continued use of settlement agreements and to the confidentiality clauses they contain. Any confidentiality clauses which prevent a signatory from making a protected disclosure are void. I did not see any recent agreements which breached this. There were some however which contained restrictions that seemed unnecessarily draconian, and I can appreciate how individuals might think they were 'gagged'. This is a hindrance to transparency. Greater care needs to be taken in the drafting of confidentiality clauses, which should only be included if they are genuinely in the public interest. All settlement agreements should be available for inspection by the CQC.

Principle 14 – Accountability

Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them**
- **the victimisation of workers for making public interest disclosures**
- **raising false concerns in bad faith or for personal benefit**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns**
- **inappropriate use of confidentiality clauses.**

70 Everyone should be held accountable for their behaviour and practice when raising, receiving and handling concerns. This applies to those raising concerns as well as to their leaders and managers. Absence of accountability puts people off speaking up, and can inhibit a person's ability to move on. Seeing a manager who has been responsible for bullying or victimisation move to a new post or even be promoted sends the wrong signal to staff and offends people's innate sense of fairness.

71 It is the responsibility of boards to ensure that there is no victimisation of or retaliation against whistleblowers, and they should be held to account for it. This will require them to maintain constant vigilance, and effective systems to enable them to keep track of what is happening within an organisation where so many people are under pressure to deliver a service. System regulators should look for evidence that this is being taken seriously. I was encouraged to hear optimism about the impact of the CQC's new inspection regime.

72 I do not believe that it would be appropriate to introduce regulation of managers at present. The Fit and Proper Person test has only just been introduced and it should be given time to bed down, and its impact to be assessed.

73 Individuals are also responsible for their own behaviour, and should be prepared to be held to account for it. Everyone who raises concerns must take responsibility for the way in which those concerns are expressed, and show willingness to accept the good faith of those who try to respond reasonably even if the conclusion is not what they would wish. It equally applies to anyone, however senior, who fails to show respect to their colleagues or is unacceptably rude. Such behaviour should not be tolerated, and those who persist with it should be held to account.

Principle 15 – External review

There should be an Independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:

- **review the handling of concerns raised by NHS workers, and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice**
- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect**
- **act as a support for Freedom to Speak Up Guardians**
- **provide national leadership on issues relating to raising concerns by NHS workers**

- **offer guidance on good practice about handling concerns**
- **publish reports on the activities of this office.**

74 I considered whether there is a case for establishing an independent body with powers to review staff concerns. I concluded that it would be wrong to take responsibility for dealing with concerns away from trusts, and would be more likely to lead to delays and additional layers of bureaucracy.

75 I also gave serious thought to the need for a new body to carry out an external review of the way individual cases have been handled and whether detriment occurred. There is a gap in the system of oversight in this area. The CQC can take account of how an organisation handles cases in its assessment of how well it is led. All the systems regulators who are prescribed persons can take action to investigate the issues raised in any protected disclosure made directly to them. But these would not normally include reviewing the way in which the organisation managed their investigation, nor the way in which the individual who raised the concern was subsequently treated. The only route available to an individual who feels he has been subject to detriment for making protected disclosure is to take a case to an Employment Tribunal. However, most do not want to take legal action: all they want is to be assured that patients are safe and to get on with their jobs.

76 Rather than establish yet another new body, which would require legislation as well as new funding, I propose that an Independent National Officer (INO) should be jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England, to operate under the combined aegis of these bodies. The INO would be authorised by these bodies to:

- review the handling of concerns raised by NHS workers where there is reason to believe that there has been failure to follow good practice, particularly failing to address dangers to patient safety or causing injustice to staff
- where this has occurred, to advise the relevant NHS organisation to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it make a direction requiring such action
- offer guidance on good practice
- act as a support for Freedom to Speak Up Guardians
- publish reports on common themes, developments and progress towards the creation of a safe and open culture in the NHS.

77 I want to emphasise I am not proposing an office to take over the investigation of concerns, nor is this a means by which a whistleblower can circumvent existing authorised processes for raising and addressing concerns. It is also not intended to replace existing legal remedies. I do not suggest that the INO should review, still less investigate historic cases.

78 The INO will have discretion to consider how an existing case is being or has been handled, and to advise an organisation on any actions they should take to deal with the issues raised. The officer would need to operate in a timely, non-bureaucratic way. He/she would not take on the investigation of cases themselves, but would challenge or invite others to look again at cases and would need sufficient authority to ensure that any recommendations made were taken seriously and acted upon. The office should be more nimble and less bound by legalistic process than a statutory body, with wide discretion to decide whether it is appropriate to get involved in a particular case. In essence the INO would fulfil, at a national level, a role similar to that played by Freedom to Speak Up Guardians locally and provide national leadership for these issues. The INO should not be expected to review historic issues.

Principle 16 – Coordinated Regulatory Action

There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

79 The review highlighted the lack of any coordination between the various regulators in their approach to whistleblowing. I believe there is scope

for the systems regulators to play a bigger role. In particular I think they should pay more attention to the record of an NHS organisation in respect of how it handles concerns, and take regulatory action where that record is poor. I have suggested that all three should work together, with the Department of Health, to define their roles and agree procedures to ensure that NHS workers are adequately protected.

80 Professional regulators could also do more. The GMC has set up an independent review, chaired by Sir Anthony Hooper, to consider how it treats doctors who raise concerns, and how they might best be supported. Its findings may be relevant to other regulators. It is important that professional regulators are aware of the context in which a referral for investigation of a medical professional is made, to ascertain whether there is any risk that it is a retaliatory referral. I am not suggesting that there should be no investigation because someone has been a whistleblower: there may be a perfectly good justification for doing so. But the regulators need to assure themselves that the referral is fair. I would also urge the professional regulators to consider what they can do to speed up their investigations into fitness to practise.

Principle 17 – Recognition of organisations

CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

81 Organisations which encourage an open and just culture should be recognised and celebrated, for example through a national award scheme, in their CQC assessment or possibly some financial incentive.

Measures for vulnerable groups

82 During the course of the Review it became clear that there are some groups who are particularly vulnerable when they raise concerns.

Locums, agency and bank staff

83 Non-permanent staff are in a more vulnerable position not only because of the temporary nature of their roles, but also because they are not fully integrated members of a team, may miss out on induction explaining how concerns should be raised in this organisation, and lack support. Yet they may bring objectivity and good practice from other organisations which should be welcomed. They should have access to all the same support and procedures as permanent members of staff, and should be encouraged to share their insights.

Principle 18 – Students and trainees

All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

84 Student nurses, other healthcare professional students, and trainees can help to spread good practice because they move around frequently. The group of student nurses I met told me that the need to pass each placement can constrain their ability to speak up: there were disturbing, but consistent accounts of students with previously good records who suddenly found themselves criticised, if not failed, after they raised a concern. We also heard of students being sent to placements despite reports by previous students about bullying behaviour, variable support by universities and petty victimisation (being given all the worst jobs) after raising a concern. The fear of referral for fitness to practise appears to be a further deterrent.

85 All the guidance and Principles that I have proposed for NHS staff should be available to support students and trainees working towards a career in healthcare. There should be additional protection for students. All training establishments should comply with the good practice in this report in relation to:

- including the importance of, and process for raising concerns in the curriculum
- the appointment of an independent person to advise and monitor the well-being of students

who raise concerns
- ensuring practical and emotional support is provided through any investigation process
- monitoring the progress of students who raise concerns, to ensure there is no sudden and unexplained dip in their performance assessments.

86 In addition, the education and training organisations and professional regulators should work more closely when assessing the suitability of placements. Where action is repeatedly not taken in respect of poor placements, the regulator should consider removing its validation of the course.

Staff from black and minority ethnic (BME) background

87 The experiences of BME staff were broadly similar to those of other staff, but without doubt they can feel even more vulnerable when raising concerns. This was partly because the culture can sometimes leave minority groups feeling excluded, and cultural misunderstandings may exacerbate difficulties. This sense of vulnerability appears to be supported by the evidence of our independent research. There is also a perception that BME staff are more likely to be referred to professional regulators if they raise concerns, more likely to receive harsher sanctions, and more likely to experience disproportionate detriment in response to speaking up.

88 Boards need to be aware that this is an issue, and should consider whether they need to take action over and above what is set out in this report to support and protect BME staff who raise concerns in their organisation.

Principle 19 – Primary Care

All principles in this report should apply with necessary adaptation in primary care.

89 It was surprisingly hard to get a clear understanding of the options open to staff who work in primary care. Little, if any, thought seems to have been given to it since the Health and Social Care Act 2012 , which abolished primary care trusts (PCTs).

90 The options would seem to be NHS England or clinical commissioning groups (CCGs), but neither are prescribed persons to whom protected disclosures can be made. Yet it seems more likely that somebody working in a very small organisation will want or need to raise a concern with, or seek advice and support from someone outside their practice particularly if their concern is about one of the senior figures.

91 I consider it essential that the support recommended in this report should be available to NHS staff who work in primary care. We heard about examples of good practice, where trainees were given induction, briefed on the policy, and felt supported by their training scheme programme director, although some trainees waited until they had completed their placement before speaking up. But it was hard to identify any source of support for other members of staff, particularly non-clinical staff.

92 Consideration should be given to how this can be provided. Federations of GP practices may be able to appoint a Freedom to Speak Up Guardian; others may be able to sign up the services of their local NHS trust's Guardian, as happens already in at least one area. NHS England should work with all commissioned primary care services to clarify policies and procedures for staff in line with the Principles in this report, which specify where employees can go for advice and support, and to register a concern.

Extending the legal protection

Principle 20 – Legal Protection should be enhanced

93 Although I do not consider the legal protection is adequate, I firmly believe it is the priority, and more effective, to address the culture and to improve the way concerns are handled so that it is not necessary to seek redress. That has been the main focus of this Review and the report.

94 There are however two steps which should be taken. Some NHS bodies which are not currently prescribed persons to whom disclosures could be

made, should be added to the list. These include NHS England, CCGs and Local Education and Training Boards. Secondly I welcome the intention to extend the scope of the legislation to include student nurses and student midwives. This should go further to include other students working towards a career in healthcare.

95 The legislation applies to all employers, not only those in the NHS, so it would not be appropriate to make recommendations for amendment which might impact on other sectors in ways that I am not aware of. However I am particularly concerned by one aspect of the legislation, which is that it does nothing to protect people who are seeking employment from discrimination on the grounds that they are known to be a whistleblower. This is an important omission which should be reviewed, at least in respect of the NHS. I invite the Government to review the legislation to extend protection to include discrimination by employers in the NHS, if not more widely, either under the Employment Rights Act 1996 or under the Equality Act 2010.

Conclusion

96 The Review confirmed that although many cases are handled well, too many are not. This has a disproportionate impact on others who are deterred from speaking up by the fear of adverse consequences or the belief that nothing will be done. It puts patients at risk.

97 I believe that the Principles and Actions in this report should together make it safe for people to speak up, and provide redress if injustice does occur. The creation of Freedom to Speak Up Guardians and an Independent National Officer in particular are key components of this, to provide support and ensure the patient safety issue is always addressed.

98 It is also important that all who raise concerns, and all who respond to them behave with empathy and understanding of others, focusing together on patient safety and the public interest.

99 I am grateful to all who have shared their experience. It has helped to shape my conclusions and has made a significant contribution to ensuring that others will have a better experience in future. I appreciate that, given my remit, some people may be disappointed that their own issues have not been addressed. Some are now so complex that I doubt that even a public inquiry would be able to resolve them.

100 I hope that genuine concerns will be investigated objectively, learning shared, and those who raise them feel supported and valued, while genuine issues about an individual's performance or conduct are dealt with separately and fairly. Anyone responsible for unacceptable breaches of the responsibilities identified in this report should be held to account, but with understanding of the pressures on them.

101 This will make the NHS a better place to work and a safer place for patients.

102 There is a great deal that can be done by well-led organisations and regulators to bring to life the Principles in this report. It will be for the Secretary of State for Health to ensure that the momentum is maintained throughout the whole of the NHS.

Recommendation 1

All organisations which provide NHS healthcare and regulators should implement the principles and actions set out below, in line with the good practice described in this report[4].

Recommendation 2

The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and to report to Parliament.

4 Principles and actions are summarised at the end of this section and the good practice is summarised at Annex A

Recommendations, Principles and Actions

Recommendations

Recommendation 1

All organisations which provide NHS healthcare[5] and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.

Recommendation 2

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Principles and Actions

Culture Change

Principle 1

Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

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

Principle 2

Culture of raising concerns: Raising concerns should be part of the normal routine business of any well led NHS organisation.

Action 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.
Action 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.

Principle 3

Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

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

Principle 4

Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.

Action 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 Referred to in these principles as 'NHS organisations' – see glossary

Principle 5

Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

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

Principle 6

Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.

Action 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.

Better Handling of Cases

Principle 7

Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

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

Principle 8

Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.

Action 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.

Principle 9

Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

Action 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.

Measures to support good practice

Principle 10

Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

Action 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.

Principle 11

Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

Action 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.

Action 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.

Action 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.

Principle 12

Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

Action 12.1: NHS England, the NHS Trust Development Authority 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 a result of having made protected disclosures.

Action 12.1: 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.

Principle 13

Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

Action 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.

Action 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.

Action 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.

Principle 14

Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

- **poor practice in relation to encouraging the raising of concerns and responding to them**
- **the victimisation of workers for making public interest disclosures**
- **raising false concerns in bad faith or for personal benefit**
- **acting with disrespect or other unreasonable behaviour when raising or responding to concerns**
- **inappropriate use of confidentiality clauses.**

Action 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.
Action 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.
Action 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 is well-led.

Principle 15

External Review: There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:

- **review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up, where there is cause for believing that this has not been in accordance with good practice**
- **advise NHS organisations to take appropriate action where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect**
- **act as a support for Freedom to Speak Up Guardians**
- **provide national leadership on issues relating to raising concerns by NHS workers**
- **offer guidance on good practice about handling concerns**
- **publish reports on the activities of this office.**

Action 15.1: CQC, Monitor, NHS TDA, and NHS England should consider and consult on how such a post 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 ongoing and future concerns.

Principle 16

Coordinated Regulatory Action: There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

Action 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.
Action 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.

Principle 17

Recognition of organisations: CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

Action 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.

Particular measures for vulnerable groups

Principle 18

Students and Trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

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

Principle 19

Primary Care: All principles in this report should apply with necessary adaptations in primary care.

Action 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.

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

Enhancing the legal protection

Principle 20

Legal protection should be enhanced

Action 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.

Action 20.2: The list of persons prescribed under the Employment Rights Act 1996 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.

Action 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.

Note: Annex B to this report contains a list of actions showing the organisations responsible for implementing each one.