NHS
Yorkshire
Ambulance Service
NHS Trust

MEETING TITLE Trust Board Meeting		**MEETING DATE** 23/05/2019	
TITLE of PAPER	Freedom to Speak Up – 6 monthly update on activity and developments.	**PAPER REF**	5.2
STRATEGIC OBJECTIVE(S)	Safe and Sustainable: Provide a safe, effective, caring and sustainable service for all patients Best People: Attract, develop and retain a highly skilled, engaged and diverse workforce		
PURPOSE OF THE PAPER	To provide an update on FTSU activity over the last 6 months to the Trust Board.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Jock Crawford (Freedom to Speak Up Guardian)	**ACCOUNTABLE DIRECTOR**	Steve Page (Executive Director of Quality, Governance & Performance Assurance)

DISCUSSED AT / INFORMED BY –
Reviews throughout the year at Trust Management Group
Monthly meetings with the FTSU Guardian, the Head of Investigations & learning and members of the Executive Team including the CEO.

PREVIOUSLY AGREED AT:	**Committee/Group:**	**Date:**
RECOMMENDATION(S)	Members of the Trust Board are only required to note the contents of this report.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Equality Impact Assessment *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☒	☐
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☒	☐

ASSURANCE/COMPLIANCE	
Care Quality Commission Choose a DOMAIN(s)	5: Well led 1: Safe
NHSI Single Oversight Framework Choose a THEME(s)	6. Leadership & Improvement Capability (Well-Led)

1. PURPOSE/AIM

1.1 To purpose of this paper is to provide the Trust Board with an update on Freedom to Speak Up (FTSU) activity and developments over the last 6 months.

2. BACKGROUND/CONTEXT

2.1 "Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS" (Francis) was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon.

2.2 Yorkshire Ambulance Service (YAS) NHS Trust was quick to implement the recommendations set out in the Freedom to Speak Up Review appointing its FTSU Guardian in June 2016. The FTSU Guardian position is a seconded role, initially for two years but was extended for a further year in June 2018. Ten FTSU Advocates were appointed to support the Guardian in this role.

2.3 Every NHS trust in England reports quarterly to the National Guardian's office providing brief details of those concerns raised through the FTSU process. This report covers those concerns raised over the second half of this reporting period specifically 1st January – 31st March 2019.

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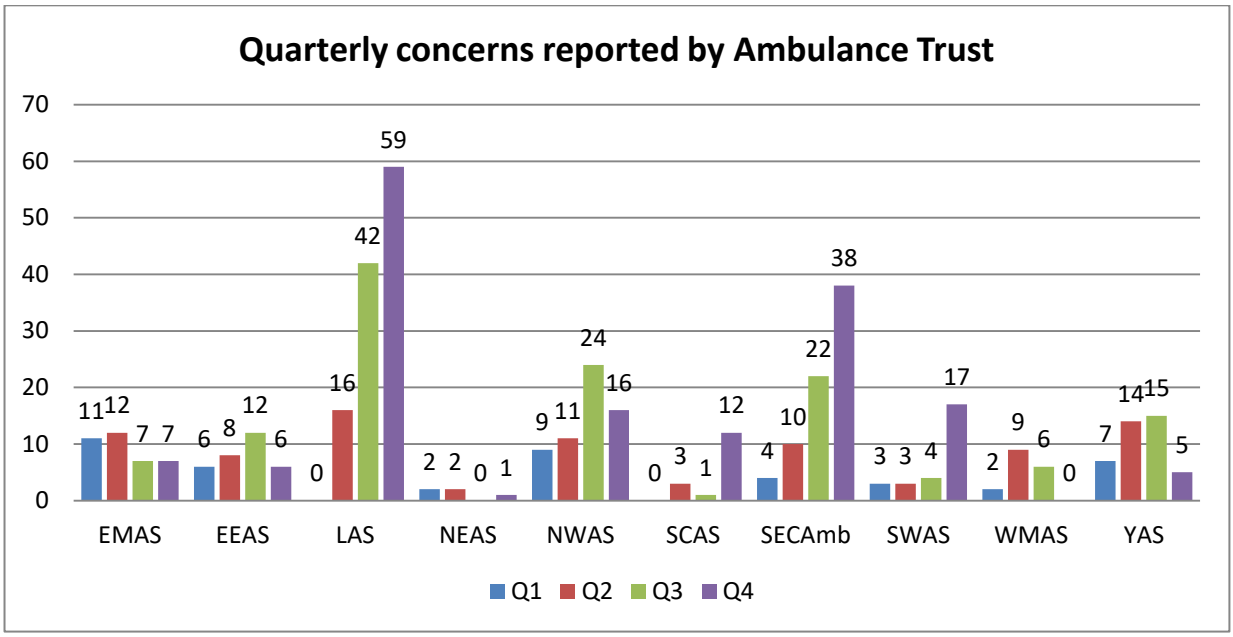
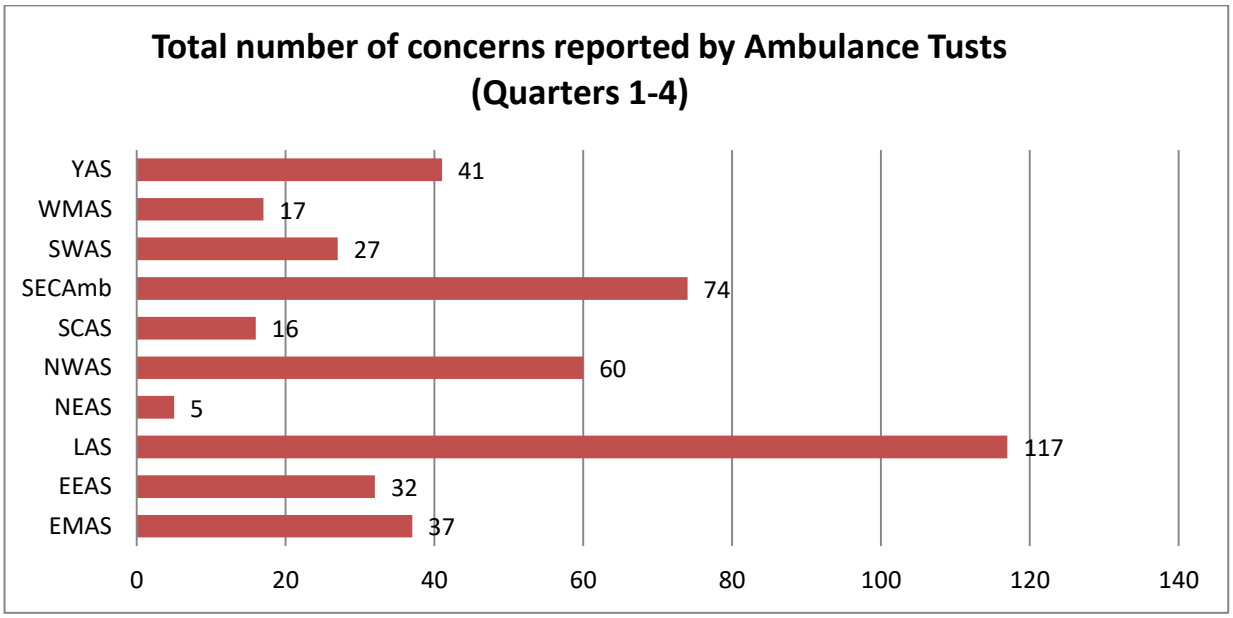
3. CONCERNS RAISED

3.1 All NHS Trusts in England are required by the National Guardian's Office (NGO) to submit brief details of all concerns raised through the FTSU process. The document "Guidance for Freedom to Speak Up Guardians, Recording Cases and Reporting Data" was updated by the NGO in July 2018. The definitions for the reporting categories have been provided wherever possible to provide board member with a better understanding of the data submitted by the trust.

3.2 There is always a difference of opinion around what an open, engaging and transparent Trust would look like in respect to FTSU concerns. Some argue that a high number of reported concerns suggest an open and engaging workforce who are not afraid to report issues or concerns while a contrasting viewpoint argues that a low number of reported concerns indicates a 'safe' organisation. Irrespective of these two contrasting viewpoints there is a general consensus that all Trusts will generate some FTSU concerns even in small numbers and those trusts who are reporting zero or "no data" may need to revisit their FTSU strategy.

3.3 The two charts below indicate the number of FTSU concerns reported by quarter and in total for the full reporting period (April 2018 – March 2019).

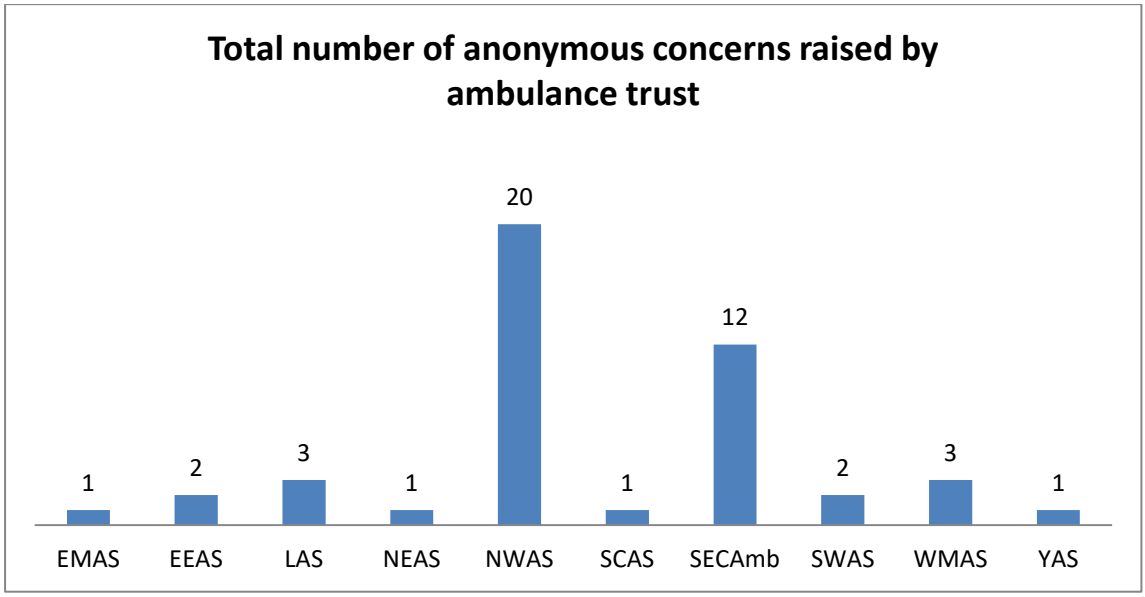




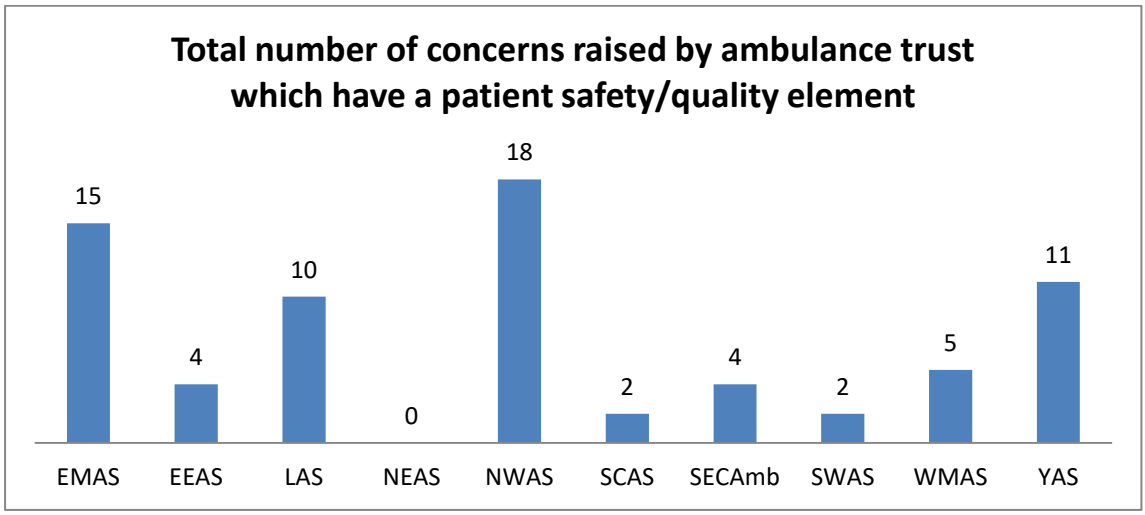
3.4 The NGO requests numerical data on concerns that meet the following criteria:

- The total number of concerns reported anonymously
- The total number of concerns which are believed to have an element of patient safety/quality
- The total number of concerns which are believed to have an element of bullying & harassment
- The total number of concerns where the reporter believes they are suffering detriment as a result of speaking up

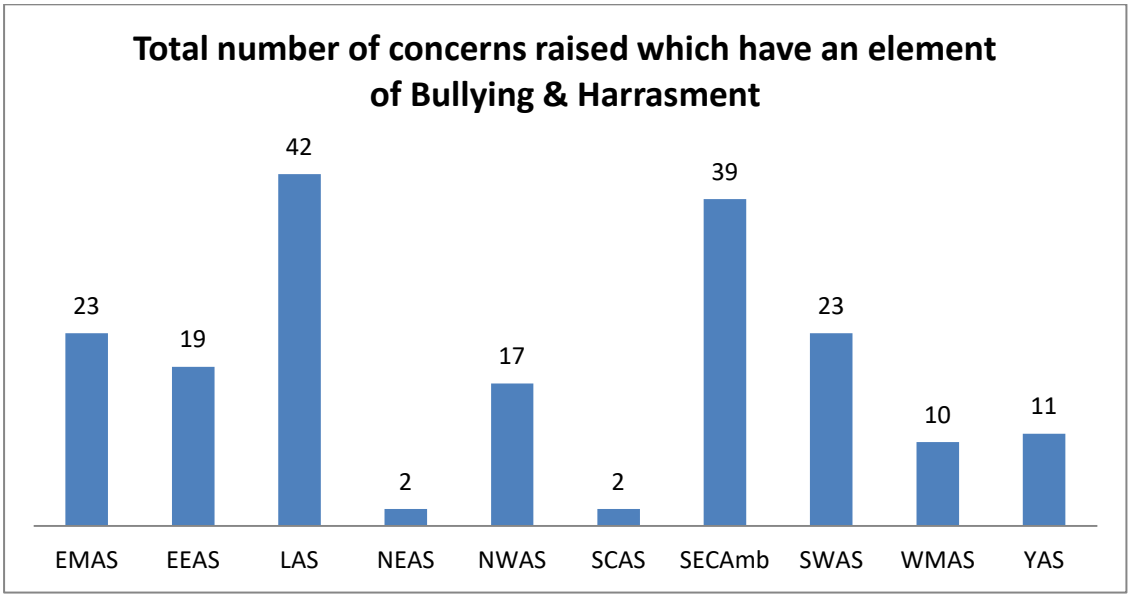
3.5 The following charts indicate the responses for the categories above from the ten ambulance trusts during this reporting period.



"Anonymous cases are those where the individual speaking up is unwilling to reveal their identity to you or to others i.e. you do not know who they are. The number of anonymous cases received may be an indicator of the level of trust workers have in the speaking up culture in the organisation." [NGO 2018]

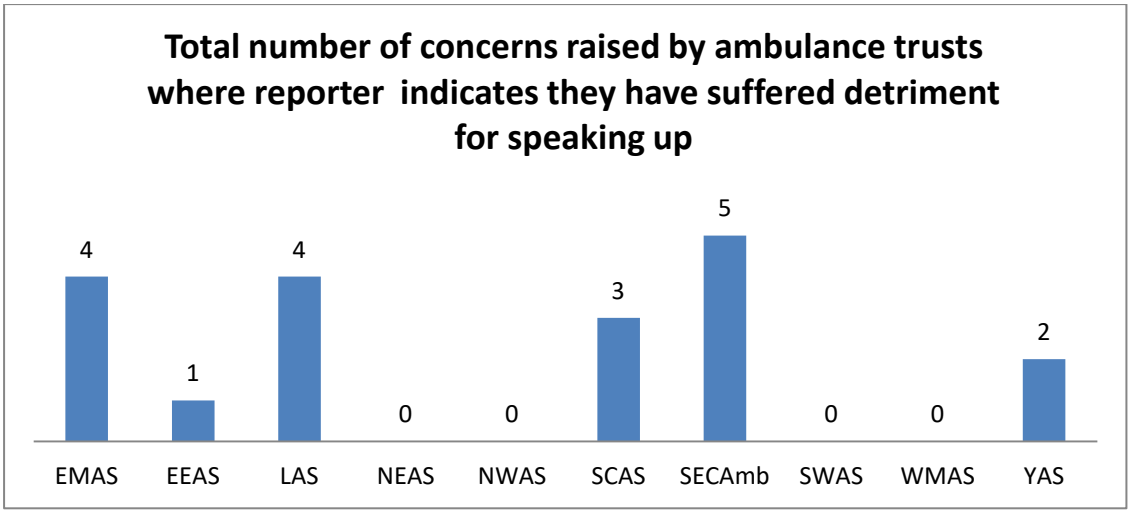


"Any case that includes elements that may indicate a risk of adverse impact on patient safety or the quality of care. Where it is not clear whether there is an impact on safety/quality without further investigation, but the individual raising the case believes that there is, then the case should still be recorded in this category." [NGO 2018]



"Any case that includes an element of bullying or harassment. Where the individual raising the case believes that there is an element of bullying or harassment then the case should be recorded in this category.

The NGO advises that the terms should be interpreted broadly and that the focus should be on the perceptions of the individual bringing the case." [NGO 2018]



"Detriment can be described as any treatment which is disadvantageous and/or demeaning and may include being ostracised, given unfavourable shifts, being overlooked for promotion, moved from a team, etc.

You should record the number of cases brought to you where an individual feels they have suffered detriment as a result of speaking up. In addition, should details of a case reveal elements of detriment as described, these should also be recorded even if the individual bringing the case does not identify detriment." [NGO 2018]

3.6 The progress of all concerns raised through the FTSU process is discussed at a fortnightly concern review meeting attended by the Chief Executive, the Executive Director for Quality, Governance & Performance Assurance, the Director for Workforce and Organisational Development, the Head of Investigation and Learning and the FTSU Guardian. Although it is felt that this approach should ensure that any barriers or issues experienced by the FTSU Guardian can be addressed quickly and appropriately, achieving full attendance by members can be challenging. Nevertheless, it is generally accepted that this approach ensures senior leaders have greater visibility and understanding of the concerns being raised through FTSU.

3.7 Twenty concerns in total have been raised during the second half of the FTSU reporting period (January to March 2019). The majority of concerns originate from staff working in A&E Operations (9 concerns) with the remainder spread across EOC (5), Corporate (2), Fleet (1) and Community Resilience (1). Of the two remaining concerns one was reported anonymously and the second was from an NHS employee from another NHS trust who felt unable to report their concern through their own FTSU process.

3.8 On reviewing the subject matter of all concerns raised during this reporting period the only noticeable recurring themes are concerns where staff have challenged recruitment and selection practices which they do not feel are in line with the trust policy (6 concerns). Straightforward Health & Safety concerns were logged on four occasions and generally signposted to a more appropriate department to address.

3.9 The three patient safety/quality concerns raised by staff include:

- Concern raised about the pairing of two very inexperienced Emergency Care Assistants (ECAs) to form a Low Acuity Transfer (LAT) crew and lack of guidance and instruction for LAT crews generally.
- Concerns rose about staff compliance and adherence to an EOC Dispatch Protection SOP.
- Concerns raised about the standard of care being delivered at a local A&E department.

3.10 Other concerns not included in the above include:

- Two concerns alleging inappropriate management behaviour or Bullying & Harassment.
- Alleged failure to follow Special Leave policy.
- Concerns about the headsets being used in EOC.
- Sharing of final exam questions on an ECA course.

4. Learning from FTSU

4.1 It is important that trusts learn from those concerns which staff raise through the FTSU process. As FTSU continues to embed itself as business as usual at YAS the influence it is having in changes to working practices, policy and culture is starting to emerge. FTSU is represented at the following trust working groups:

- 111 Working Group
- Health & Wellbeing Working Group
- Post Incident Care Working Group

4.2 As part of the work undertaken as co-chairs of the National Ambulance Network (NAN) for FTSU Guardians Jock Crawford and Anna Price (EEAS) presented to the Ambulance Leadership Forum their findings from concerns raised through the FTSU process to ambulance Guardians over the past two years. As a result of this work and in conjunction with the work being conducted by the National Guardian, the Association of Ambulance Chief Executives (AACE) have now signed up to the "Alliance Against Bulling, Undermining and Harassment in the NHS"

4.3 The National Guardian's Office conduct case reviews which specifically review the handling of concerns and the treatment of people who have spoken up, where there is evidence that good practice has not been followed.

4.4 Case reviews identify areas where the handling of NHS workers' concerns do not meet the standards of accepted good practice in supporting speaking up and make recommendations to NHS organisations to take appropriate action where they have failed to follow good practice. Case reviews will also commend areas of good practice.

4.5 The five case reviews published to date offer and excellent opportunity for trusts to benchmark their own policies and practice against the recommendations detailed in these reports, it is also anticipated that the areas for improvement identified in these reports are likely to form the starting point for discussions during CQC inspections under key line of enquiry (KLOE) 3 as part of the well led question. As such it would be prudent for YAS to review these case studies and benchmark their current processes and performance against these recommendations.

5. PROPOSALS/NEXT STEPS

5.1 In April the trust appointed Luzani Moyo as the new Freedom to Speak Up Guardian for YAS. Luzani's substantive position in the trust is as an Advanced Emergency Medical Technician and has worked on A&E for approximately 14 years. In addition to assuming the responsibility for heading up FTSU at YAS Luzani has also secured a Quality Improvement fellow position within the trust and will share his time across both roles. In addition to passing on his best wishes and good luck to the incoming Guardian the outgoing Guardian would also like to thank members for their support over the past three years and for the opportunity to represent the trust regionally and nationally.

6. RISK ASSESSMENT

6.1 No risks identified at the current stage in the process that requires addition onto the risk register.

7. RECOMMENDATIONS

7.1 Members of the Trust Board are only required to note the contents of this report.

8. APPENDICES / BACKGROUND INFORMATION

Alliance Against Bulling, Undermining and Harassment in the NHS
https://www.cqc.org.uk/sites/default/files/20190404%20-%20AntiBullying%20Alliance%20-3April2019%20%28002%29.pdf

National Guardians Office Case Reviews :
https://www.cqc.org.uk/national-guardians-office/content/case-reviews