Witness Name: Helené Donnelly
Statement No.: 1
Exhibits: N/A
Dated: 11/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF HELENÉ DONNELLY

I, Helené Donnelly, will say as follows: -

1. I am currently the Head of Safety Culture at Nuffield Health (since June 2022). I also conduct work in a personal capacity across the NHS and wider health and social care sector, supporting with culture change, implementing and enhancing Freedom to Speak Up services and undertaking speaking engagements. Despite being employed by Nuffield Health I make this statement in a personal capacity.

2. I qualified as a Nurse in 2002 and worked for Mid Staffordshire NHS Foundation Trust as a Staff Nurse, Senior Staff Nurse and, later, Emergency Nurse Practitioner from 2002-2008. From 2008-2013 I worked for Staffordshire and Stoke on Trent NHS PCT as a Band 7 Nurse Practitioner. From 2013 -2022 I worked as Ambassador for Cultural Change and Lead Freedom to Speak Up Guardian for the Midlands Partnership Foundation NHS Trust. In 2014/2015 I was asked by the Secretary of State for Health and Social Care to support Sir Robert Francis with the Freedom to Speak Up Review. I have since continued to support the National Guardian Office with implementation, development and training of Freedom to Speak Up Guardians.

3. Following on from my own personal experience raising concerns at Mid Staffordshire NHS Foundation Trust (2007-2008) I believe there have been improvements regarding increasing awareness and support when people do speak up. The Francis Freedom to Speak Up Review (2015) into whistleblowing, speaking up or raising concerns in the NHS has done much to instigate fostering open and honest speaking up cultures within the NHS. However, it is my belief that much more still needs to be done to ensure managers take appropriate action when workers speak up, that learning and improving is the core focus and a humane, just and emotionally intelligent approach is taken to support all involved.

4. We know people are speaking up across health and social care systems daily and often get great responses and actions taken as a result. However, we also know that this is not always happening, and the result can be catastrophic. So, in my opinion, the focus needs to shift from encouraging people speaking up, to how leaders respond when they do.

5. I was appointed in 2013 to act as NHS Ambassador for Culture Change and pioneered the Freedom to Speak Up Guardian role to support all NHS staff to raise concerns, ensuring the voice of the frontline is heard clearly and at a senior level within organisations.

6. I continue to speak with health and social care leaders and workers all over the country throughout health and social care. So, in addition to my own personal experience of raising concerns in the NHS, I can relay anecdotal experiences of others as evidence to the Inquiry. I am sure there is data available to support and echo much of what I hear throughout the NHS about culture, for example, the annual NHS Staff Surveys, The National Guardian Office quarterly and annual data reports, The Freedom to Speak Up Guardian Survey, Freedom to Speak Up Index Reports, NHS England' Culture Reviews, the Kark Review, various reports and reviews conducted by Roger Kline etc.

The National Guardian Office:

7. The National Guardian Office (NGO) has been integral to establishing a national network of Freedom to Speak Up Guardians (FTSUGs) throughout the NHS and beyond. The NGO staff have worked tirelessly to register, support, train and offer ongoing guidance and recommendations to all Freedom to Speak Up Guardians and organisations. The case reviews they have conducted have offered vital evidence and intelligence to how systems and processes could and should be improved. This is shared across health and social care for others to adopt and for the benefit of all. The quarterly data collected by all Guardians provides further vital information and analysis in areas including, the number of concerns raised via FTSUGs, the professional groups speaking up, whether these are anonymous or openly reported, reports of suffering detriment having spoken up, concerns with an element of patient safety/quality of care, worker safety and wellbeing, inappropriate attitudes and behaviour and claims of bullying or harassment. This information is compared alongside the NHS annual staff

survey results and other indicators to triangulate particular areas of concern and focus attention on improvements.

8. It is unfortunate that the NGO has not been given statutory powers to ensure regulation. Many people have said to me since its establishment that the NGO "*lacks teeth*". Instead, the NGO can only guide and recommend on processes and practices.

9. It is also unfortunate that the office has not had the necessary funding required to make the full impact it could on fostering open and honest reporting cultures. It is my understanding that it has had its budget cut yet again this year, so vital initiatives cannot be established or developed further. For example, the case reviews the office have previously conducted have been extremely valuable and more could be completed if the office had the necessary funding and resources. The data collection and analysis could be improved to provide even greater insights into themes and trends, particularly regarding discrimination and whether groups face increased barriers to speaking up and/or detriment when they have. I feel this underfunding is a lost opportunity and could be viewed as paying lip service to the purpose of the NGO.

10. A lack of enforced standardisation has meant that overtime Guardians have been inappropriately appointed to roles. This has led to ineffective Guardians at best and damaging at worst. This has, on occasion, undermined the role in general and brought its credibility and purpose into question. The standardised national FTSU Guardian job description (2018) has since been established, along with FTSU guidance for leaders and reflection toolkits for Boards (2022). This is welcomed, but it is still only guidance and recommendations. I believe the carrot verses the stick approach to change and improvement is always preferable. However, it has also been my experience that the best leaders and best organisations actively seek out advice and guidance on how they can continually evolve and improve. The leaders who lack such will or initiative need to be instructed on what standards and processes they must adhere to. The inclusion of Freedom to Speak Up into the 'Welled Domain' of CQC inspection has of course been immensely useful. However, statutory power would enable the NGO to enforce specific FTSU best practice and monitor whether it is adhered to - this should not be viewed as a 'nice to have' but as essential.

Freedom to Speak Up Guardians:

11. The Freedom to Speak Up Guardian role became a requirement of the NHS national standard contact in 2017. The role should be viewed as an additional compliment to other routes and systems for people to speak up to raise anything that is concerning them or getting in the way of them doing a good job, including their own psychological safety and wellbeing. Speaking up should therefore be seen as business as usual, and this means people should feel enabled to speak up in team meetings or huddles, during one to ones and directly with their line manager, or manager's manager. However, this may not always be possible or appropriate, so having as many different routes and opportunities for people to raise concerns or simply discuss some issues they may be worried about is vital. The Freedom to Speak Up Guardian should be someone who people can go to in strict confidence to discuss any concerns they may have. They must not breach this confidence unless they have permission, or a disclosure of a potential criminal or public safety risk has been made. They are then duty bound to escalate the concerns appropriately, although still protecting confidentiality as much as possible.

12. The post holder should have been appointed in line with the NGO recommendations and be registered with the NGO and completed training via the NGO. To be effective Freedom to Speak Up Guardians need to act as a conduit relaying concerns and experiences from all levels of the organisation to the executive and Board level. In order to do this, they must act independently and impartially. The must meet regularly with the CEO, Chair, Executive Lead for Freedom to Speak Up and Non-Executive Lead for Freedom to Speak Up to ensure those with ultimate responsibility are aware of concerns raised without it being lost in translation or dumbed down. As the most senior leaders they must be aware of any barriers or determent staff face when speaking up and they must set the tone and lead by example empowering all members of the workforce to speak up. The Freedom to Speak Up Guardian must also present their reports to a full public Board in person.

13. If concerns have been raised via the Freedom to Speak Up Guardian and they have reason to believe these have not been addressed by the organisation appropriately, the Guardian has a responsibility to escalate the concerns further to the Board and to external organisations, authorities and regulators if necessary.

14. The Freedom to Speak Up Guardian is fully trained by the National Guardian Office to ensure they are aware of their role obligations and responsibilities and can always seek confidential advice from the National Guardian Office. The national and regional Freedom to Speak Up Guardian networks provide a safe space for Guardians to gain peer support and advice, to learn and share best practice. I believe the Freedom to Speak Up Guardian role has played a vital part in increasing awareness and support for those needing to speak up. Yet it is important to remember this role is not a panacea. It must work in conjunction with other routes and processes to provide safe speaking up cultures and intelligence. Ensuring safe and effective speaking up cultures is everyone's responsibility, not just the Freedom to Speak Up Guardian's. It is not the responsibility of the Guardian to conduct investigations or resolve the concerns. They are there to signpost or escalate the concerns to the most appropriate managers/ teams to address. However, as previously stated, the do have a responsibility to escalate the concerns further if they are concerned hey are not being addressed sufficiently and/or patients or staff safety could be compromised.

15. The NHS is still very hierarchical and especially so in the Boardroom. Many executives have confided in me that they would fear challenging some decisions made around the boardroom table – which is concerning. It has been stated that performance, fiscal management and reputational focus is still paramount. Although many Trusts and organisations claim patient care and safety is the main focus, this is often not what is demonstrated or felt in reality. This often boils down to conflicting system directives and pressure to hit targets. Even if senior executives challenge this, they can feel their concerns are dismissed.

16. Investigating concerns further is often seen as an inconvenience which Trusts do not have the time or money for. This lack of curiosity and failure to seek meaningful assurances must be recognised and priority given to hearing from to workforce, at all different levels to gather intelligence 'warts and all'. Senior managers have told me they only want to tell the Board good news and '*what they want to hear*' – this means complex and difficult issues are not always reported to the Board in full or a sanitised version of events and actions is supplied.

17. The Freedom to Speak Up Guardian role should be utilised by all senior leaders and members of the Board to give information and insights into how staff feel, what are the hotspots or areas of concern and what are the common themes and trends of issues raised. The Guardian can play a vital role in holding the mirror up to the executives

and Board so they can see how they are perceived by the workforce, and what implications their actions have. Ensuring the relevant Board members hear the full narrative and context of concerns if required and as appropriate. The FTSUG can recommend further and/or different actions are taken to address concerns and enhance safety cultures.

18. I am aware that the Freedom to Speak Up Guardian roles have been criticised for working within and on the payroll of organisations, so cannot be viewed as truly independent. I do understand this and agree. But I do not necessarily have confidence in privately-run, for-profit companies employing the Guardians as an alternative. It has always been my belief that the National Guardian Office should be appropriately funded and resourced as an independent body to employ the Guardians who would then be posted to work within individual Trusts and organisation. This would mean they are part of the organisation's workforce (although not on the payroll), are visible and on-site, but would remove any perceived conflicts of interest regarding independence and impartiality or profit-making incentives.

Management of Change:

19. Cultures within large organisations continually evolve and, in some instances, can have both negative and positive impacts. It is also true that no one single culture exists, but many micro-cultures within the macro-organisation. Senior leaders need to be vigilant to subtle shifts and changes in teams and departments within organisations, especially within the NHS when the one constant is change.

20. How managements of change are conducted is so important in creating and maintaining open, honest and supportive speaking up cultures. When people are not given appropriate information and consultation about potential changes, they become fearful, apprehensive and defensive. They may fear losing their jobs so are less likely to want to raise concerns at that point in time. This is concerning as the period of change and associated disruption may create incidents/safety risks which staff should feel enabled to speak up about at the time.

21. The lack of transparent information also provides a void to be filled with gossip and rumour, which further exacerbates the problem and does not provide a psychologically safe environment for people to work and speak up as business as usual. Managements

of change must be handled sensitively and as transparently as possible. The tendering/commissioning of services often supresses the transparency and leaves staff feeling very vulnerable.

22. Staff should be consulted and involved in potential improvements or changes. The staff working at the front line, night and day, will have the experience and best insights into what is likely to work and what is not. Yet they are far too frequently not involved, nor given any meaningful feedback about the decision-making processes, outcomes and services they are expected to provide.

Training:

23. The National Guardian Office worked with Health Education England to create training for all NHS workers to complete. This is divided into three modules and should be completed sequentially. The first module is for all workers to complete and raises awareness about what 'Speaking Up' is and how to do it. The second module, entitled 'Listening Up' is for all managers or leaders to complete and focuses on how to recognise when someone is speaking up to them, how to respond, actively listen and what actions to take. The final module entitled 'Following Up' to for all senior leaders, including Board level, and focuses on setting the tone and ensuring the right cultures exist for speaking up and listening up to work effectively. Many organisations have now mandated this training, which is a promising sign, however, this is not the case for all. Additionally, I have been told on several occasions that some senior leaders simply get their assistants to log into the training and complete it on their behalf. Also, much of the training can be quickly clicked through and the real value lost if individuals do not take sufficient time to engage with it fully. This literally becomes a tick box exercise.

24. This training references other great work, research and information on supporting and maintaining safe cultures and understanding the specific impacts on individuals. It is my opinion that the Civility Saves Lives campaign, understanding Human Factors, the leadership work of Prof. Micheal West and Megan Reitz should all be incorporated into mandatory training for all NHS and social care workers. Understanding everyone's responsibilities in this is just as important as health and safety, or manual handling training and failures to do so can have devasting affects.

Leadership Development Training:

25. Further standardised and compulsory training is required for leaders in the NHS. I would suggest this needs to be face to face, or at least via a virtual classroom to ensure meaningful engagement and discussion. Too often leaders are appointed into leadership roles without the key skill and competency required. The banding or grading system in the NHS often means that clinical staff are restricted in their professional development because once they reach Bands 6 or 7 the opportunities to progress are limited clinically. Commonly the only roles available at a higher band involve leadership and management responsibilities. So, people are forced into taking on such roles to progress, yet they lack the essential people management skills to do these roles justice. They are often appointed because they have been great clinicians or great at managing budgets, but these skills do not necessarily translate to managing complex individuals and teams in a compassionate and collective way. You cannot necessarily teach compassion, but you can certainly give aspiring leaders the opportunity to learn about and enhance the skills required to act with compassion and competency. Leadership candidates should only be considered and successful if they can demonstrate compassionate and emotionally intelligent responses through a values-based recruitment process.

26. Many leaders, some very senior, in the NHS have revealed to me that they did not feel developed or supported when they were appointed into their leadership roles. This can have damaging implications. Firstly, the individual leader many not feel able to recognise when their colleagues are speaking up, or know how to respond appropriately, this then leads to either inappropriate actions or no actions taken to address the issues. Secondly, the leaders may attempt to supress the concerns, especially if they do not hold the ability or seniority to affect change, they may not feel safe to escalate the concerns to their own managers due to a fear of appearing inept or becoming 'the problem' themselves. Thirdly, this results in potential harm because the concerns have not been addressed and a lost opportunity for learning and improving. Finally, this sets a defensive culture in which people see no point in speaking up to their leaders because nothing changes, they do not trust the process, they are not thanked and they have no meaningful feedback.

27. It is important to note that I am frequently told by leaders and managers that they do not have time to respond in the way they would like. They often do not have time to proficiently conduct a fact-finding exercise or investigate concerns because they are

too time pressured with competing priorities and ever-increasing demand on service provision. Whilst I believe this to be true, it is also fact that if time is taken to priorities the wellbeing of staff who are raising concerns, to actively address the issues raised in good time, this will prevent much greater time-consuming processes later, and crucially could prevent harm occurring to both patients and staff. Staff who feel safe to speak up and see action taken will not need to take sickness absence or leave the team due to stress and conflicts, thus ensuring retention and good staffing levels with which to deliver safe services. So, enabling and empowering leaders to proactively rather than reactively address issues and concerns will prevent further disruption down the line.

Mediators and Investigators:

28. It would also prove immensely useful if the NHS and Social Care could provide a pool of highly trained independent mediators and investigators to be called upon when needed. It is my belief that to mediate or conduct robust investigation you must have the required time and training. Successful mediation is a skill and should not be conducted by someone who does not know what they are doing. Yet, I hear of so many cases where this appears to have been the case and has made matters worse.

29. Many people speak up about conflict and difficult relationships with colleagues at work. Too often these issues are left to fester and become worse. Resulting in staff going off sick, leaving and/or being advised to submit a formal grievance as the only way to resolve the problems. Often these conflicts are dismissed as two people just not getting on, or someone being 'too sensitive', lacking resilience or being resistant to their manager attempting to manage them. Of course, this can sometimes be the case, but it is important to understand what is sitting behind some of these behaviours and supporting managers to refine and adjust their style to get the best out of everyone. It is also important to look at whether the issues and behaviours are not solely focused on one or two people but could be indicating a wider bullying culture. Whatever the factors, it is vital to understand the potential link and impact on patient safety or quality of care, even if this is indirect. Because the staff involved are distressed, distracted, or go off sick or leave, this results in poorer outcomes and experiences for patients.

30. Leaders must feel confident in having difficult yet supportive conversations, were required, to nip these issues in the bud. They must also feel confident that they can

offer mediation as a first step to potentially resolve the conflict. If they do not have trained mediators, they can call upon to support this in a timely manner, this opportunity is far too often lost. Of course, there are numerous independent mediation business who can provide this service at a cost. But his cost is often not seen as a valuable use of NHS money, and so this does not happen and the problems simply escalate.

31. If the issues cannot be resolved via this route and a formal investigation is required, an appropriate investigating officer must be appointed. Again, I hear far too many reports of very busy managers being tasked with conducting a complex investigation without designated time and having to do this on top of running their own teams/departments. This puts them under undue pressure and means they do not conduct a thorough enough investigation. Or the duration of the investigation is extended and becomes an increased distressing period for all involved. Often these managers are also not seen as being truly independent as they work for the organisation or may be perceived as having a conflict of interest because they know the people involved. Even if this is only a perceived conflict, this sets a feeling of mistrust from the outset and brings the credibility of the whole investigation into question. Thus, undermining everyone's confidence. So, a pool of trained investigators who ensure the terms of reference are appropriate and adequately reflect the full concerns raised, who are independent, and have dedicated time to conduct the investigation properly would be very helpful in increasing confidence and reassurance.

Leaders Views of Freedom to Speak Up:

32. Many leaders have confided in me that they are wary of the Freedom to Speak Up Guardian roles and the wider Freedom to Speak Up initiative. They have described their concerns as feeling, '*dread and fear, staff can complain about you, but you can't answer back, You might get sacked if staff speak up about failures - reputational damage, Overall Negative feelings – time wasting, staff moaning, staff trying to avoid their own performance issues, Staff Telling tales, Senior leaders/peers might think I'm a bad manager or I can't cope, Guardian might judge me or might not be confidential, My best isn't good enough – personal criticism, Lost, Lonely, Vulnerable'*.

33. These feelings are understandable, and we must ensure leaders are fully engaged in the Freedom to Speak Up ethos and not disempowered by it. They need to understand what the Freedom to Speak Up initiative is, and crucially what it is not. It is always

preferable and encouraged for people to speak up to their line manager or manager's manager as a first option. So, leaders need to ensure they are visible, approachable and giving their staff confidence to speak with them first. Giving timely feedback is also essential, to prevent staff feeling they have to go to the Guardian or escalate further.

34. Managers must understand it is everyone's responsibility to set the right tone. To lead by example and speak up themselves if they believe the open and honest culture is not as it should be and if systems and processes are failing. We need to support our leaders to lead with compassion and empathy to prevent defensive responses.

Human Resources:

35. Leaders require guidance and information from Human Resources (HR) colleagues to ensure appropriate actions are taken and policies and processes are followed. This all sounds fine on paper, however, in my own experience and that of many I have spoken with subsequently, this does not always happen in practice. In fact, it is alarming the number of times I hear that inappropriate advice has been given by HR or HR workers have not paid due diligence.

36. I will speak in very generalised terms about this subject, and it is important to stress that there are many great HR departments and individual HR practitioners working in the NHS and wider health and social care. However, we will only ever achieve genuine lasting cultural change in relation to staff raising concerns if we focus on what is not working and what needs to improve.

37. The greatest concern is that HR focuses too much on policy and process. This is understandable, that is fundamentally their role. However, this also means that the 'Human' element of the Human Resources role is not focused on and too often becomes a secondary consideration, if at all. The compassionate and emotional intelligent approaches are lost. A 'just culture' approach is essential in creating open, honest and learning organisations. HR teams need to take responsibility for ensuring leaders are aware of this and this approach is always taken from the outset.

38. I have always approached my role as a qualified nurse with the mantra of treating others as I would wish to be treated myself. I feel many HR practitioners would be more effective if they took this same approach. Putting themselves in the other persons position, understanding there are always at least two sides to a story (not just the

manager's) and recognising issues are infrequently black or white is important – there is very often a lot of grey areas. Making sure that issues are not missed, and links are made between concerns is vital, whilst ensuring potential safety concerns are not conflated with issues regarding performance or speculation about motivations. All views and contexts must be taken into consideration and appropriate action taken to address all concerns, whilst triangulating common themes or elements. This is difficult to do and most often does not fit neatly within one policy or process. So being curious, compassionate and 'thinking outside of the box' is vital.

39. Many HR teams are also under resourced and capacity issues play a significant part in the team's ability to spend appropriate time on cases and to view complex issues via a compassionate lens.

40. The way processes are instigated and conducted is important. Such as the timing and way information is communicated to individuals involved in informal and formal processes. For example, being summoned to a meeting with a manager and not knowing what this is about can be very distressing. This is often made worse if the manager has an HR representative in attendance, but the individual was not given prior knowledge of this or given the opportunity to have someone present to support them. This also prevents them from having the opportunity to prepare themselves with required information before the meeting and puts them at a disadvantage. Being called to such meetings can be extremely intimidating and consideration of this must be a priority.

41. Timing is crucial, for example, people being informed they must attend a meeting without context or are to be involved in an investigation or subject to performance management last thing on a Friday is not helpful. They cannot then get access to anyone to discuss this further and gain more information and may have to spend a weekend worrying.

42. Those who are raising a concern which results in an investigation must have sight of the terms of reference and agree that these accurately reflect the concerns they are raising.

43. For all those involved in an investigation, being told they cannot discuss this with anyone is very isolating and adds to the anxiety. Whilst confidentially in such cases is of course vital, there must be consideration and signposting to where people can get

support and have a confidential, safe space to off load. Freedom to Speak Up Guardians can be useful in this instance, but staff need to know this and be signposted appropriately to a confidential point of contact.

44. Ensuring staff involved in an investigation, including all witnesses (not just the persons raising the concern or the subject of the concern), must be given a clear understanding of the process to manage expectations from the outset. They must understand and agree to how and when they will be communicated with during the process. They must understand how and what detail of the outcome will be shared with them so they can understand restrictions. They must be regularly kept updated throughout the process and the progress (as appropriate) and of any delays, so they know they have not been forgotten. They must also be given information at the conclusion with as must detail of the outcome as possible and potential next steps and support. They must receive this information prior to this being communicated to the wider workforce so they are not blindsided. They must also be genuinely thanked for their involvement.

45. Many NHS staff tell me the HR function and role is focused on protecting the organisation. Many have also said to me over the years, *'keeping the organisation out of court and out of the headlines*.' This worries me, as if people just perceive this to be the role of HR they will not have confidence in it and this will prevent safe speaking up cultures.

46. This also links back to the need for all leaders to be aware and competent in their duty to recognise and respond to concerns raised. It is far better to prevent issues escalating into formal processes as these become adversarial and defensive. Again, missing opportunities to learn and improve. It is preferable to support leaders to manage situations and difficult conversations in a compassionate and transparent manner to ensure the issues are resolved and appropriate action taken. Ensuring that thanks and feedback is given. If concerns must progress to formal policy and process, it is still essential that this is done in a compassionate, empathic and 'just' way. Ensuring the welfare of <u>all</u> involved, not just the managers or senior colleagues involved.

47. There is also still far too much focus on <u>who</u> is speaking up or <u>why</u> they are speaking up including speculations as to their motives. This is irrelevant – <u>what</u> they are saying, and the concerns raised must be the focus. If the person raising the issues is proven

to be genuinely mistaken, then this must me independently varied and fed-back, with thanks for speaking up.

48. In my experience very few people speak up vexatiously or maliciously, in comparison to those who do so with good intent. If people are genuinely wrong that is fine, it is still better that they spoke up about their concerns so assurances can be sought.

49. When people speak up about something they are worried about, but not sure, they are often expected to provide evidence to support their concerns. Of course, if they can supply evidence this is immensely useful and should be encouraged, however the burden of proof should not be on the individual, and leaders and HR workers must understand this. Too often, concerns are never acted upon until it is too late because there was apparently insufficient evidence. This acts as a barrier to people coming forward to speak up because they fear they will not be taken seriously without evidence. If people can see they are being listened to and fact-finding action is taken to seriously address the issues raised, this will give reassurance and confidence that there is value in speaking up. This can then often trigger and encourage others to come forward who can provide further context and corroborate information and the sufficient evidence required.

50. HR and leaders collectively have a responsibility to look at the bigger picture and not just limit investigating for fear of being seen as '*going on a witch hunt*'. Leaders need to be curious; they need to gather and triangulate information and soft intelligence via many different sources to truly ensure a comprehensive a transparent approach has been taken.

51. If people are suspected of only raising concerns to deflect from their own performance issues or wrongdoing, then the two issues must be separated and addressed simultaneously, especially if the concerns they raise relate to potential safety issues. Too often these two things are conflated, and the alleged safety concerns get lost in the process. Or, the issues are separated, but not dealt with simultaneously, allowing opportunity of for further confusion and delay which can cause harm to patients and staff.

52. I would like to see a full review of Human Resources and leadership development across the NHS and social care to ensure an updated approach is taken. I believe people hide behind employment law and/or the laws are not fit for purpose in the

current climate. The HR policies and processes set out to follow are often impeding the Freedom to Speak Up progress. These should be updated to reflect the changing landscape. There have now been numerous inquiries and reviews of failures, scandals and catastrophic harm across the NHS and social care. These have reported that people were speaking up (whistleblowing) on the inside. They have recommended improvements in HR practices and processes to ensure safety concerns are escalated and addressed thoroughly- and not just ignored, swept under the carpet, or individuals removed (paid off), but not held accountable.

53. HR must ensure genuine and transparent appropriate actions are taken. If someone has a finding of gross misconduct made against them following a thorough and appropriate investigatory process, this should not have to be kept confidential. This does not happen in criminal law, so why should it occur in employment law. This only serves to enable bad people to hide and prevents trust and confidence in processes and outcomes. Even if appropriate and robust action has been taken, if this is not shared with those who have bravely and diligently spoken up it will not instil confidence and will not help to foster open and honest reporting cultures.

Accountability of Leaders:

54. The Kark review (2019) of the Fit and Proper Persons Test has been widely welcomed and rightly so. If this is to have any meaningful impact the full recommendations and the Nolan Principles must be adhered to. If leaders are found to have not upheld their duty in this, they must be prevented from simply leaving their organisation and obtaining a similar post in another organisation. This should not just pertain to senior leaders/executives and non-executive leaders, but all leaders/managers in the NHS.

55. It is my understanding that Registered Managers with the CQC (who are not always classed as senior leaders or executives) could have a finding of gross misconduct made against them following an investigation by their employer and even be dismissed due to this, yet there is no requirement or obligation for them or the employing provider organisation to inform the CQC. Regulation 7 Schedule 4 (Part 1: Unfit Person Test and Part 2: Good Character) sets out that they CQC only needs to be informed if the person is bankrupt or insolvent, is included in the safeguarding children's barred list or the adult's barred list, they are prohibited by or under any enactment, if they have any convictions or if they have been struck-off a professional register. This appears to enable managers who conduct themselves in an inappropriate manner, who bully or

intimidate or who fail in their duty to take appropriate action when safety concerns are raise with them, to be at their liberty to gain leadership employment in another hospital, care home or hospice. It is my view that this is entirely irresponsible and needs to be addressed.

56. A specific professional register for all managers in health and social care should be created to track and monitor all managers. This should include whether they have been subject to any disciplinary processes regarding bulling, harassment, inappropriate conduct, or behaviours and what the outcome was, even if they leave the organisation before the process is concluded. This should also include whether they have failed to adequately respond to, and address concerns raised to them about potential safety or quality of care risks.

NHS Demand and System Pressures:

57. The impact on cultures of the ever-increasing demand on NHS and social care cannot be underestimated. The increasing system pressures alongside lack of resources is having a detrimental effect on staff speaking up, because, either people get sidelined as not a priority, people do not want to be seen as adding to the pressure or being 'difficult' or people feel discouraged from speaking up as it is deemed to be futile.

58. We know that many workers are leaving health and social care roles to work in other countries on industries because they feel overwhelmed and undervalued. This only serves to increase pressure on those who remain. Many newly qualified nurses are leaving the profession because they report feeling unsafe and unsupported in their development. The increase in work related stress means that people either take sickness absence or carry on trying to work, but with significant cognitive impairment which is not safe for them or their patients. Annual data collected by the National Guardian Office tells us the concerns mostly raised via Freedom to Speak Up Guardians relate to inappropriate behaviours and conduct of colleagues and the associated impact on worker wellbeing. These attitudes and behaviours refer to interpersonal relationships and conduct between colleagues. The people who work in the NHS and social care workforce are its greatest asset. So, in order, for them to care for patients and service users in the best way possible, the workforce itself must first be cared for. Worker wellbeing and psychological safety is essential for safe cultures to exist. Many different reviews and reports across the NHS have identified sexual harassment, racism, bullying, lack of cultural awareness, inappropriate attitudes and

behaviours and failures to support staff with neurodiversity. Priority must be given to stamping out these appalling behaviours and inequalities in a meaningful and impactful way.

59. This means staff must have safe spaces they can speak up and be supported. There have been many great initiatives and improvements focusing on prioritising worker wellbeing and support such as the NHS People Plan, NHS Improvement Speak Up Support Scheme, National Guardian Office/FTSUGs, Duty of Candour, Patient Safety Improvement Response Framework, National Speaking Up Policy, etc. However, there are still far too many reports of NHS staff feeling they are being mistreated and discriminated, so clearly more must be done. The poor behaviours and conduct of some colleagues mean NHS staff feel they must just survive rather than thrive at work. Managers who consistently fail to address this must also be held to account.

Safe Staffing:

60. I speak to staff in the NHS and social care who constantly tell me staffing levels are unsafe. This is not just the number of staff on each shift, but the skill mix and experience of staff. We know many experienced staff are leaving the NHS due to feeling burnt-out and a lack of recognition for the valuable work they do. This means junior staff are not supported and do not benefit from the experience and knowledge of senior colleagues and clinicians. We also know that many newly qualified staff are leaving to work elsewhere because of the lack of support, development and increasing pressure. So, I reiterate how important it is to provide the right cultures and supporting the wellbeing of the workforce.

61. The government reports record numbers of NHS staff currently employed; however, this is in the context of record service demand and an increasingly aging population requiring complex care, treatments and interventions. There may have been increases in the number of training and recruitment places available for doctors, nurses and allied health professional, but if we are haemorrhaging experienced and knowledgeable staff out the other end, this would appear futile.

62. It is my opinion that England should follow Scotland whose safe staffing legislation will come into force in April 2024. Having the appropriate number of staff on shift, with the appropriate skill mix will ensure greater support and capacity to develop the workforce and provide better, safer care. But will also provide greater supervision, scrutiny and

monitoring of colleagues to ensure they are practicing and behaving safely and appropriately. However, to meet the required legislated staffing levels, we need the appropriately skilled and supported staff available to utilise. The culture must therefore come first and ensure the workforce are cared for to enable them to care for patients.

63. When incidents, failures or harm occurs too often staff feel blamed, afraid and unsupported. Often the problems are linked to a lack of staff and lack of experienced leaders/clinicians.

64. The newly introduced Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to responding to incidents in a way that enables learning and improving. Just culture is vital to this, and I believe linking the launch of PSIRF with FTSU helps to set the tone and context of compassionate engagement, with both staff and patients. It is one thing asking people to be open and honest when things have gone wrong, but if they fear retribution, this simply will not happen. Blame cultures prevent learning and improving and contributes to staff burn-out and staff leaving to protect their own wellbeing. This means increased attrition rates and missed opportunities to deliver the best possible care to patients and service users due to a failure to support and retain staff.

65. Staff and leaders throughout the NHS are consistently and persistently stating staffing levels are negatively impacting on patient safety and outcomes. This must be addressed, without delay, and in a sustained manner, as the NHS Workforce Plan is manifestly not enough.

66. Retention of the skilled and experienced workforce requires just and responsive cultures. Barriers to achieving this must be broken down via comprehensive training and awareness of human factors, genuine compassionate and civil leadership (leading by example) and freeing up staff (psychological safety) to think about moral injury and their duty to speak up. Firstly, focusing on emotional, civil and compassionate

engagement with our NHS leaders and colleagues, so they are then enabled to bring to life, safe, compassionate engagement with our patients and relatives.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 11/04/2024