The Regulation and Quality Improvement Authority

Review of the Operation of Health and Social Care Whistleblowing Arrangements

September 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

Public Concern at Work

Public Concern at Work (PCaW)[2] is an independent charity and legal advice centre. The cornerstone of the charity's work is a confidential advice line for workers who have witnessed wrongdoing, risk or malpractice in the workplace but are unsure whether or how to raise their concern. The advice line has advised over 20,000 whistleblowers to date; this unique insight into the experience of whistleblowers informs their approach to organisational policy development and campaigns for legal reform.

In February 2013, PCaW established the Whistleblowing Commission to examine the effectiveness of whistleblowing in the United Kingdom and to make recommendations for change. The Whistleblowing Commission published its report in November 2013.[3] The key recommendation of the Commission was the creation of a statutory Code of Practice, which sets out the principles for effective whistleblowing, which can be taken into account by courts and tribunals considering whistleblowing claims.

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf
[2] Public Concern at Work - http://www.pcaw.org.uk/
[3] The Whistleblowing Commission report, November 2013 - http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

Membership of the Review Team

Gary Walker	Former National Health Services Trust Chief Executive; self-employed interim and turnaround specialist
Patricia Snell	Deputy Director Quality Improvement and Patient Safety, Guy's & St Thomas National Health Services Foundation Trust
Mark Hudson	Associate Director of Workforce, Guy' & St Thomas National Health Services Foundation Trust
Cathy James	Chief Executive, Public Concern at Work
Bob Matheson	Adviser, Public Concern at Work
Hall Graham	Head of Programme for Reviews - RQIA

Janine Campbell	Project Administrator - RQIA
Jim McIlroy	Project Manager - RQIA

Table of Contents

Executive Summary

Encouraging staff to raise concerns openly as part of day to day practice, is an important part of improving quality of service and providing assurance of patient safety. When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care.

This however, has not always been the case in the health service. The public inquiry into poor standards of care at the Mid Staffordshire National Health Service (NHS) Foundation Trust found that staff voices had been consistently ignored by the Trust Board. Freedom to Speak Up, the report of a review led by Sir Robert Francis was published in February 2015 and concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk.

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisations culture.

It is essential that all organisations work towards developing an open and honest reporting culture. Staff must have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately.

The findings from this review demonstrate that whistleblowing is mostly seen as a very negative term, which has not been helped by media portrayal. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There is also confusion as to what the term 'whistleblowing' actually referred to. Some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for health and social care in Northern Ireland that reflects current thinking. This should be supported by increasing the awareness for all staff about the needs and benefits of raising concerns.

A positive step in encouraging the raising of concerns would be the development of an independent helpline to provide advice and support for health and social care staff in Northern Ireland. It is recommended that this should be run as a pilot, with a subsequent evaluation to decide on whether or not to continue it.

Extremely positive steps have been taken in the area of visible leadership, but further development in this area is necessary. The review team considers that it is important to assess the effectiveness of any developments in this area.

For a system of raising concerns to work effectively, training needs to be available for staff who receive the concerns. They must be appropriately skilled in relation to managing and investigating concerns. Organisations must also assess how recording and reporting concerns fits in the overall governance process, including incident reporting and complaints

The Freedom to Speak Up report considered that feedback was an important part of the process. The review team was told that organisations generally provided feedback on action that was taken as a result of raising a concern. They considered that any method of feedback is to be supported, but feedback to individuals is essential.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. Most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

It is not acceptable for organisations to assume a low level of raising concerns is positive; they must each 'test the silence' to gain assurance that the process of raising concerns is working well in their organisation.

This report makes 11 recommendations to improve whistleblowing arrangements within HSC organisations in Northern Ireland.

Section 1 - Introduction

1.1 Introduction

Health and social care services have been developed to promote the health, wellbeing and dignity of patients and service users. The people who deliver these services generally want to do the best they can for those they serve. However, for a variety of reasons, there will be occasions when things go wrong in the workplace. Encouraging staff to raise concerns openly as part of day to day practice is an important part of improving quality of service and providing assurance of patient safety.

When concerns are raised and dealt with appropriately, at an early stage, corrective action can be put in place to ensure the continued delivery of high quality and compassionate care. It is essential that all organisations should work towards development of an honest and open reporting culture, where staff have the confidence to bring forward any concerns they may have, without fear and with the knowledge that any genuine concern will be treated seriously and investigated appropriately and properly.

The term whistleblowing has no legal definition and is not enshrined in any legislation. Originally, the term developed from British police officers (bobbies) blowing their whistles to alert the public to criminals, while later, private business owners would use their own whistles to alert the police to the fact that a crime was being committed. US civic activist Ralph Nader is said to have coined the phrase in the early 1970s to avoid the negative connotations associated with other words such as informers and snitches. However, more recent media coverage, emphasising negative outcomes for whistleblowers, has led to whistleblowing being seen as a generally negative term, which could have a detrimental effect on the way staff approach raising concerns within their organisations.

The whistleblowing charity, PCaW defines whistleblowing as “A worker raising a concern about wrongdoing, risk or malpractice with someone in authority either internally and/or externally (i.e. regulators, media, MPs).”

Whistleblowing, or raising a concern, should be welcomed by public bodies as an important source of information that may highlight serious risks, potential fraud or corruption. Workers are often best placed to identify deficiencies and problems before any damage is done, so the importance of their role as the eyes and ears of organisations cannot be overstated.

Whistleblowing best practice and legislation[4] to protect workers raising concerns developed following a number of disasters and public scandals in the late 1980s and the early 1990s:

- capsizing of the passenger ferry the Herald of Free Enterprise (1987)
- the explosion on the Piper Alpha oil platform (1988)
- the train collision at Clapham Junction London (1988)
- the Bristol Royal Infirmary (1991-1995)

In each of these cases, workers had been aware of dangers but did not know what to do or who to approach, were too frightened to speak out due to fear of losing their jobs or being victimised, or spoke out but weren't listened to. Raising concerns or whistleblowing is therefore essential to:

- safeguard the integrity of an organisation
- safeguard employees
- safeguard the wider public
- prevent damage

Employers, if they truly want to know about malpractice, risk, abuse or wrongdoing in their organisation, must take steps to encourage workers to raise concerns. Effective arrangements for raising those concerns should be a part of every healthy organisation's culture. Workers who are prepared to speak up about wrongdoing should be recognised as one of the most important sources of information for any organisation seeking to enhance its reputation, by identifying and addressing problems that disadvantage or endanger other people.

The benefits of encouraging staff to report concerns include:

- identifying wrongdoing as early as possible
- exposing weak or flawed processes and procedures which make an organisation vulnerable to loss, criticism or legal action
- ensuring critical information gets to the right people who can deal with concerns
- avoiding financial loss and inefficiency
- maintaining a positive corporate reputation
- reducing the risks to the environment or the health and safety of employees or the wider community
- improving accountability
- deterring workers from engaging in improper conduct

The public inquiry into poor standards of care at the Mid Staffordshire NHS Foundation Trust[5] found that staff voices had been ignored by the Trust Board.

[4] Public Interest Disclosure (Northern Ireland) Order 1998 - http://www.legislation.gov.uk/nisi/1998/1763/contents

[5] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - 6 February 2013 - https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Robert Francis QC concluded that:

"The board did not listen sufficiently to its patients and staff, or ensure the correction of deficiencies brought to the trust's attention.
Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities."

In his report he went on to recommend that the:

"Reporting of incidents of concern relative to patient safety, compliance with the law and other fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting."

Dame Janet Smith in the inquiry[6] which followed the conviction of Harold Shipman, a GP who had killed at least 215 patients over a period of 24 years, commented in her report:

"To modern eyes, it seems obvious that a culture in all healthcare organisations that encourages the reporting of concerns would carry great benefits. The readiness of staff to draw attention to errors or near misses by doctors and nurses and the facility for them to do so, could have a major impact upon patient safety and upon the quality of care."

Subsequently in her report she stated:

"I believe the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance, or health of another could make a greater contribution to patient safety than any other single factor."

A whistleblowing commission was established in February 2013 by PCaW to examine the effectiveness of existing arrangements for workplace whistleblowing in the United Kingdom and to make recommendations for change.

The commission made 25 recommendations,[7] including a recommendation that a code of practice drafted by the commission be adopted.

[6] The Shipman Inquiry - 27 January 2005 http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp

[7] Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK - November 2013 http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf

The code of practice sets out standards to assist with development of effective arrangements for raising concerns and provides advice for organisations in relation to:

- written procedures
- training, review and oversight of arrangements for raising concerns
- dealing with anonymity and confidentiality
- legislation related to raising concerns

In November 2014, Whistleblowing in the Public Sector – a good practice guide for workers and employees[8], developed in conjunction with PCaW, was published by the four United Kingdom audit offices. It was designed to provide information for public sector workers on how to raise concerns and what they should expect in turn from their employers. It also provided guidance for public sector employers on the benefits of having a robust system for raising concerns and on how to encourage workers to raise concerns and deal effectively with those concerns.

Freedom to Speak Up[9], the report of a review led by Sir Robert Francis was published in February 2015. The review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

The review concluded that although many cases are handled well, too many are not. If this leads to others being deterred from speaking up in the belief that nothing will be done, patients may be put at risk. It also emphasised the importance of all who raise concerns, and those who respond to them, the need for behaving with empathy and understanding towards others, focusing together on patient safety and the public interest.

Organisations should have an ethos where genuine concerns are investigated objectively and learning shared, while supporting those who have raised the concerns. Genuine issues about an individual's performance or conduct should be dealt with separately and fairly.

The report set out a number of principles and actions under the following headings:

- culture change
- better handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- enhancing the legal protection

[8] Whistleblowing in the Public Sector - A good practice guide for workers and employers – November 2014 - http://www.niauditoffice.gov.uk/wb_good_practice_guide.pdf

[9] Freedom to Speak Up - An Independent Review into Creating an Open and Honest Reporting Culture in the NHS – February 2015 - http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

The report emphasised the need for a change in culture, with boards devoting both time and effort to achieve this change. As part of the culture change, raising concerns should be part of the routine business of any organisation and speaking up should become part of what everyone does and is encouraged to do. The report considered that policies and procedures should not distinguish between reporting incidents and making protected disclosures and that visible leadership at all levels of the organisation was essential in supporting the culture of raising concerns.

All organisations should have systems in place to support the raising of concerns both formally and informally and organisations should have a range of staff available to whom concerns may be reported. All staff should receive training in their organisation's approach to raising concerns and there should be transparency about incidents and concerns and how an organisation has responded to them.

The report also recommended that there should be an external review of systems for raising concerns, in the form of an Independent National Officer. The Care Quality Commission (CQC) was also encouraged to take account in the well-led domain of its hospital inspections, of how organisations handle concerns that are raised.

In its response to the Freedom to Speak Up review, the Scottish Government decided that:

- non-executive whistleblowing champions would be introduced in each NHS Scotland Board
- further national whistleblowing events would be provided to designated policy contacts within boards, with a view to roll out locally
- the Cabinet Secretary would write to all NHS Scotland Boards to draw attention to relevant local actions identified within the review report and ask that Health Board Chairs and Chief Executives consider how these recommendations can be implemented locally
- the Cabinet Secretary would write to Healthcare Improvement Scotland as the relevant scrutiny body in NHS Scotland, to ask it to consider and feedback on how the report's recommendation on scrutiny may be implemented

Additionally, the Scottish Government committed to: "The development and establishment of an Independent National (Whistleblowing) Officer (INO), to provide an independent and external review on the handling of whistleblowing cases".

In November 2015, a consultation paper regarding the establishment of an INO was produced by the Scottish Government[10].

[10] Consultation on proposals for the introduction of the role of an Independent National (Whistleblowing) Officer for NHSScotland Staff - http://www.gov.scot/Publications/2015/11/5123

Regarding professional regulation, in his report, The Handling by the General Medical Council of Cases Involving Whistleblowers[11], the Right Honourable Sir Anthony Hooper noted that it is sometimes said that a whistleblower is a person who raises concerns externally, that is with persons other than his or her employer. In his opinion that was not correct. He went on to say that many people who raise concerns, do not, at the time of raising concerns see themselves as whistleblowers. They may be ignorant of the protections afforded to those who raise such concerns. They are more likely to come to regard themselves as whistleblowers if they suffer detriment as a result of raising concerns or if no action is taken in response to their concerns. The report made a number of recommendations regarding the position of raising concerns in relation to professional regulation.

1.2 Context for the Review

The Public Interest Disclosure (Northern Ireland) Order 1998[12] sets out the legislative basis for those workers who raise concerns about wrongdoing and makes provision about the kinds of disclosures that may be protected; the circumstances in which such disclosures are protected and the persons who may be protected. The Order also lists the organisations to which disclosures of information may be made under the Order.

On 17 February 2009, Circular HSS (F) 07/2009[13] provided whistleblowing guidance for HSC organisations, setting out their responsibilities and providing a model policy template for all organisations to adapt to their own circumstances. The circular stated that organisations should have clear arrangements in place to assist staff with reporting concerns. If these were not in place, organisations were to take steps to devise and implement them in line with the model policy template.

In March 2012, the then Minister for Health, Mr Edwin Poots, wrote to Chief Executives of all HSC bodies, asking them to bring the contents of his letter to the attention of all employees and make it available alongside each organisational whistleblowing policy. The letter set out a number of principles that every employee should expect in relation to raising concerns within their own organisation, which included:

- The right to whistleblow - every member of staff should be confident that managers at all levels would respond positively to expressions of concern and should it be necessary they would be protected from victimisation.

[11] The handling by the General Medical Council of cases involving whistleblowers – 19 March 2015 - www.gmc-uk.org/Hooper_review_final_60267393.pdf

[12] The Public Interest Disclosure (Northern Ireland) Order 1998 - https://www.dhsspsni.gov.uk/articles/public-interest-disclosure-northern-ireland-order-1998

[13] Circular Reference: HSS (F) 07/2009 - 17 February 2009 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hssf-2009-07.pdf

- The right to be heard by management and a responsibility to speak up – staff should feel empowered to speak up if they see, or become aware of practice which is unsafe, or creates unacceptable risks to patients or clients. Managers and leaders at all levels would then be responsible for creating and maintaining an atmosphere of mutual support and mutual learning.

The letter concluded with encouragement for staff to raise genuine concerns where appropriate and emphasised that this was a vital element of good public service based on the values and principles that are at the heart of Health and Social Care.

In December 2014, the then Department of Health, Social Services and Public Safety (DHSSPS) commissioned Sir Liam Donaldson to carry out a review of the arrangements for assuring and improving the quality and safety of care in Northern Ireland. His report, The Right Time the Right Place[14], made a number of recommendations including that "the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the minister".

In August 2015, Dr Paddy Woods, Deputy Chief Medical Officer, commissioned RQIA to undertake a review of the operation of HSC whistleblowing arrangements.

This review forms part of the Department of Health's (DoH) overall review of HSC whistleblowing arrangements.

The report makes 11 recommendations in order to continue the journey towards normalisation of raising of concerns within HSC organisations in Northern Ireland.

1.3 Terms of Reference

The terms of reference for this review were:

1. The review will consider the:
    a. existence (current, consistent, robust)
    b. operation (understanding, training, learning)
    c. accessibility, availability, support
    d. governance

    of Arm's Length Bodies' whistleblowing arrangements.

2. In light of the findings of the review RQIA will identify any recommendations for improvement to the arrangements.

[14] The Right Time the Right Place - An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland – December 2014 - https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf

1.4 Exclusions

The review has excluded the whistleblowing arrangements within the Northern Ireland Fire and Rescue Service and RQIA.
The Northern Ireland Guardian Ad Litem Agency has also been excluded from the review. These organisations will be assessed by the DoH[15] at a later stage.

Circulars, guidance, standards, reviews and reports which arise during the course of this review will not be assessed as part of this review and will be highlighted for consideration in the future.

1.5 Review Methodology and Scope

The scope of the review included the following organisations:

DoH – Arm's Length Bodies *	
Belfast Health and Social Care Trust	Patient and Client Council
South Eastern Health and Social Care Trust	Business Services Organisation
Northern Health and Social Care Trust	Northern Ireland Blood Transfusion Service
Southern Health and Social Care Trust	Public Health Agency
Western Health and Social Care Trust	Northern Ireland Medical and Dental Training Agency
Northern Ireland Ambulance Service Health and Social Care Trust	Northern Ireland Practice & Education Council for Nursing and Midwifery
Health and Social Care Board	Norther Ireland Social Care Council

PCaW, a whistleblowing charity, is accepted as a leading authority in this field. They:

- advise individuals with whistleblowing dilemmas at work
- support organisations with their whistleblowing arrangements
- inform public policy and seek legislative change

[15] On 9 May 2016, as part of the restructuring of the Northern Ireland government departments, Department of Health, Social Services and Public Safety has been renamed the Department of Health.

RQIA engaged PCaW to assist with a number of pieces of work to inform the review.
The review included the following stages, designed to gather information about the presence and operation of HSC whistleblowing arrangements:

- A review of relevant literature set out the context for the review and identified appropriate lines of enquiry.

- Meetings with professional regulatory and representative organisations to obtain their views about whistleblowing arrangements, to help inform the review.

- A review of each organisation's whistleblowing policy and procedures against best practice guidance.

- Staff engagement and obtaining their views was a key element of this review. A staff questionnaire was developed and distributed to staff in the organisations subject to the review. Secondly, RQIA worked in partnership with PCaW to hold focus groups with a range of staff groups in each of the organisations.

- Information was obtained from the HSC staff survey which included a number of questions about whistleblowing arrangements.

- Validation visits to each of the organisations were undertaken, to meet with staff who have responsibility for the operation of whistleblowing arrangements and other senior staff including board members.

- A stakeholder event to present the initial findings from the review to representatives from each of the organisations. The majority of organisations involved in the review were represented, with 40 delegates attending the event. The findings from the review were discussed, and delegates made suggestions for enhancing and taking forward the recommendations from the review.

Findings from questionnaires, meetings with organisations and feedback from the stakeholder event were collated, and the information used to inform this report. The report is an overview report and provides a regional view of arrangements for raising concerns and provides general recommendations to improve the process for raising concerns in Northern Ireland. No organisation is reported individually.

Section 2 - Findings from the Review

2.1 Engagement with Interested Stakeholders

During the planning stages of the review, RQIA met with several professional regulatory and representative organisations, including the General Medical Council[16], the Pharmaceutical Society of Northern Ireland[17], the Royal College of Nursing[18], the Chair of the Trade Union Forum, UNITE[19], and UNISON[20]. The meetings were designed to obtain their views about current whistleblowing arrangements within health and social care, with the intention of using the information to inform the review.

Professional Regulatory Organisations

The General Medical Council and the Pharmaceutical Society of Northern Ireland are the professional regulatory organisation for doctors and pharmacists respectively. They have legal powers to set guidance, and have done so in relation to the raising of patient safety concerns and in the professional duty of candour.

Both organisations have guidance[21,22] in relation to raising concerns, which places a duty on the professionals they regulate to raise concerns where they believe that patient safety has been compromised. They also state that professionals must be open and honest with their regulators, and with each other to ensure that concerns are raised where appropriate.

Both regulators provided advice and support to members who were considering raising a concern or had already done so. They generally did not raise a concern on behalf of a member, but supported them to raise their concern through the mechanisms within their own organisation.

Unions

Not all Unions representing workers in health and social care engaged with RQIA during the review. The Royal College of Nursing, UNITE and UNISON did take the time to engage.

The Unions represent the professional interests of staff working in a range of health and social care specialties and settings.

---

[16] General Medical Council - http://www.gmc-uk.org/
[17] Pharmaceutical Society of Northern Ireland - http://www.psni.org.uk/
[18] Royal College of Nursing - https://www.rcn.org.uk/
[19] UNITE - http://www.unitetheunion.org/
[20] UNISON - https://www.unison.org.uk/
[21] General Medial Council guidance on whistleblowing - http://www.gmc-uk.org/DC5900_Whistleblowing_guidance.pdf_57107304.pdf
[22] Pharmaceutical Society of Northern Ireland guidance on whistleblowing - http://www.psni.org.uk/wp-content/uploads/2012/09/Guidance-on-Raising-Concerns.pdf

They provide advice and support to members who were considering raising a concern or had already done so, but generally did not raise a concern on their behalf. They encourage their members to raise concerns through mechanisms already in place within their own organisation.

All Unions provide guidance[23,24,25] on whistleblowing for their members. During discussions, Unions were able to cite many examples where staff were afraid or unwilling to raise concerns.

Outcome of the Discussions

The outcome of these discussions was consistent with the themes that were uncovered during the review. In summary all organisations considered:

- the term whistleblowing as being negative and not conducive to encouraging staff to raise concerns
- the current arrangements were not suitable and many cases were not managed appropriately
- there was a lack of awareness and training in relation to whistleblowing

All organisations welcomed any improvements to the arrangements for raising concerns. They expressed a willingness to be involved in the development of new arrangements, as well as becoming a more integrated part of these new arrangements.

2.2 Review of Whistleblowing Policies

In the initial stage of the review, all HSC organisations were asked to submit their whistleblowing policies. In order to review these documents, PCaW adopted the methodology used by the United Kingdom National Audit Office (NAO), following their review of a number of United Kingdom government departmental and Arm's Length Bodies' whistleblowing policies in 2014. This methodology was devised following wide consultation by the NAO, and closely follows the requirements on best practice for whistleblowing arrangements, encapsulated in the Whistleblowing Commission's Code of Practice[26] and the British Standards Institution's whistleblowing guidance.[27]

---

[23] Royal College of Nursing guidance on whistleblowing - https://www.rcn.org.uk/employment-and-pay/raising-concerns/guidance-for-rcn-members

[24] UNITE guidance on whistleblowing - http://wbhelpline.org.uk/resources/raising-concerns-at-work/?doing_wp_cron=1395055349.5939080715179443359375

[25] UNISON guidance on whistleblowing - https://www.unison.org.uk/get-help/knowledge/disputes-grievances/whistleblowing/

[26] The Whistleblowing Commission was established by PCaW in early 2013. The Independent Commissioners took evidence from stakeholders in whistleblowing and published a report in November 2013 that included a proposed Code of Practice, which forms the basis of PCaW's best practice guidelines. Copies of the full Commission report, including the Code of Practice are available on http://www.pcaw.co.uk/

[27] BSI publicly available specification 1998:2008 http://shop.bsigroup.com/forms/PASs/PAS-1998/

Each organisation's whistleblowing policy was assessed against eight criteria, which are based on good practice and current whistleblowing legislation. The NAO review criteria[28] are summarised below. While each policy has been reviewed against the detailed criteria, this report contains general trend analysis and a summary of main findings. The categories for review adopted by the NAO and used to assess the policies reviewed for this report are:

Setting a Positive Environment for a Whistleblowing Policy

a. **Commitment, clarity and tone from the top**
This involves making it clear to staff that any concern will be welcomed; it should reassure the reader, who may be thinking of raising a concern that the organisation's leadership will take it seriously and will not punish the employee if the concern turns out to be untrue, as long as the employee had reasonable suspicion of wrongdoing.

b. **Structure**
It is also important that guidance is easy to use so that readers are clear how they should raise a concern. The policy should include information relating to all areas of whistleblowing and provide comprehensive guidance for employees. It should be clear, concise and avoid including irrelevant detail that might confuse readers.

c. **Offering an alternative to line management**
Concerns may relate to behaviour of line managers or an employee may be unwilling or unable to discuss concerns with immediate management. Thus, alternative channels inside the organisation should be offered. Staff may be unwilling to approach extremely senior people with a concern, so the alternatives offered should be suitable.

d. **Reassuring potential whistleblowers**
Guidance should make clear that it is serious misconduct to victimise employees who are preparing to raise a concern, or have already done so. Similarly, it should make clear that employees who knowingly disclose false information will be subject to disciplinary action.

e. **Addressing concerns and providing feedback**
Whistleblowing policies should set out procedures for handling concerns. This will reassure readers that their concern will be taken seriously and also that wrongdoing can be identified and dealt with appropriately. The organisation should be clear about the actions it will take to investigate the concern and the feedback it will be able to provide to whistleblowers. Best practice will also give a general indication of the timescales involved in handling concerns, e.g. how long it will take to arrange an initial meeting, provide feedback etc.

[28] National Audit Office – Assessment criteria for whistleblowing policies – January 2014 - https://www.nao.org.uk/wp-content/uploads/2014/01/Assessment-criteria-for-whistleblowing-policies.pdf

Supporting Whistleblowers

a. **Openness, confidentiality and anonymity**
Guidance should make sensible and realistic statements about respecting whistleblowers' confidentiality. It should also outline the potential issues that could arise from employees reporting a concern anonymously.

b. **Access to independent advice**
Employees may need advice where they feel unsure or unaware of how to raise a concern. Guidance should address the point and identify how to contact potential advisers.

c. **Options for whistleblowing to external bodies (prescribed persons)**
Guidance should make employees aware of how they can raise a concern outside the organisation, e.g. to an external auditor or regulator. This may be a legal obligation in certain circumstances, for example where there is evidence of a criminal act. Guidance that follows best practice should encourage internal reporting, as this is where the concern can be addressed most effectively and where employees will receive the greatest protection. However, guidance should also identify the procedure for external reporting as well as outline potential bodies that employees can raise a concern with.

Assessment of Whistleblowing Policies

With these criteria in mind, an overall assessment is now provided of the organisations' policies as a whole against each of the above criteria, commenting on common trends and gaps in the policy wording overall.

a. Commitment, clarity and tone from the top
In order to achieve an excellent rating: there should be a stated commitment to maintaining high ethical standards and taking concerns seriously; the language should be inviting and reassuring; and there should be a clear distinction between whistleblowing and other concerns or grievances. Only a small number of the policies (two out of 14) scored an excellent rating in this category.

As a general rule, there was a lack of evidence of senior leadership contained in the policies reviewed. While many of the policies referred to a commitment on the part of the organisation to ensure that the policy and accompanying processes work in practice, rarely did this specifically refer to the leadership of the organisation. This is essential if the policy aims to instil trust and confidence in the process for all staff.

While in many of the policies reviewed, there was language stating that the organisation was committed to operating at very high standards, rarely was a specific body (such as the organisational board or equivalent) referred to.

Many of the policies referred to the Public Interest Disclosure Order as the starting point for the introduction to the policy or as the reason for having the policy. If the aim of the policy is to encourage staff to speak up and to ensure that it is safe and acceptable to do so, then this will not set the right tone from the start. In this category, two policies were rated as excellent, eight as satisfactory and four as poor.

b. **Structure**
An excellent rating in this category required the policy to be concise and well-presented, provide clear guidance that is both factual and informative, and guide the reader through the process in easy to follow language (flowcharts are recommended).

A third of the policies reviewed achieved an excellent rating in this category. One of the problems with many of the policies reviewed was a legalistic approach to the policy wording (i.e. leading with the Public Interest Disclosure Order as the introductory wording). Using the language of complaints and grievances and or/mixing management guidance for handling a concern were also issues with a number of the policies scrutinised.

An impersonal approach with a focus on an individual's responsibilities as opposed to focusing on the organisation's commitment to protect those raising a concern or disclosing information, would also have resulted in a low score for this category. Of the 14 policies, four were rated excellent, six satisfactory and four poor in this category.

c. Alternative to line management
Suggesting that workers consider raising a concern with their manager, but at the same time offering alternatives to the line management are both essential for any whistleblowing policy to be effective. It is clearly important that the line management process is included in the 'how to' section of any whistleblowing policy, as this will often be the starting point for raising a concern for most workers. However, it is also vital that any policy includes an alternative to line management, as the concern may relate to the behaviour of the line manager or it may be that line management is involved in the wrongdoing.

To gain an excellent rating, the policy should consider inclusion of appropriate contacts for the types of concerns being raised, have a flexible approach to when a concern might be raised outside of the management line and provide name and contact details for those designated to receive concerns. A number of the policies required individuals to raise the issue with their line manager first; this would have resulted in a low score because although it is proper to go through line management it should never be an absolute requirement. Six policies scored highly in this category, five were satisfactory and three were rated as poor.

d. **Reassuring potential whistleblowers**
An excellent policy will include language to assure the individual that they will not face sanctions for honestly raising a genuine concern, irrespective of whether they later turn out to be wrong. It will confirm that there are sanctions for victimising those who raise a concern or for preventing a concern being raised, and will also confirm that it is an abuse of the policy, and therefore a disciplinary offence, to knowingly raise a false concern.

Only one policy scored an excellent rating in this category. The main reason why many policies received a low score was the fact that disciplinary sanction was applied to frivolous/malicious/vexatious concerns. In order to strike the right balance, policy wording should only apply sanctions to the knowingly false concern. Extending sanctions more broadly, risks adding to the already numerous hurdles that whistleblower's experience, without necessarily reducing the number of concerns raised which lack merit.

e. **Addressing concerns and providing feedback**
In order to score highly, the policy wording should reassure readers that their concern will be taken seriously and also that wrongdoing will be identified and dealt with appropriately. It should include a summary of the procedures for handling concerns, an indication of how long before feedback is provided (noting that this will depend on the nature of the concern), an outline of the type of feedback whistleblowers can expect (while respecting the confidentiality of those being investigated), and clear guidance to managers on how to handle concerns (which may be published as a separate document[29]).

In this category, five policies scored highly, six satisfactory and three were rated as poor. Examples of difficulties in the policies reviewed include a lack of clarity around timescales (or no mention of this at all), using the language of a grievance process, requiring written statements from those using the policy, and long detailed manager's guidance which could confuse the concerned member of staff wishing to use the policy.

f. Openness, confidentiality and anonymity
An excellent rating clearly explains the difference between anonymity and confidentiality, and outlines where confidentiality cannot be maintained (e.g. where legal obligations mean that the identity of the person providing the information will have to be disclosed). It will encourage open disclosure and outline the difficulties with raising a concern anonymously (namely difficulties investigating, providing feedback, and protecting an individual's identity). The NAO review also requires a statement that anonymous disclosures are preferable to silence about wrongdoing.

[29] Public Concern at Work would suggest that this should be published as a separate document in order to keep the messaging in the policy itself as clearly aimed at those considering raising a concern.

It might also be sensible to say that anonymous concerns will be investigated in any event, but that there may be limitations on the protection available if the identity of the person raising the concern is unknown.

Difficulties with the wording of policies reviewed, included reference to the duty of confidentiality being more important than anything else, in terms of how the individual approached the raising of concerns and/or limited assurances around the protection of the individual's identity. In the latter case, the most common problem identified was that the policy stated that the organisation will use 'all reasonable steps' (or similar wording) to protect identity rather than confirming that if asked, the individual's identity will not be disclosed unless required by law. Other common issues with this category included use of confusing language about data protection, and patient confidentiality being referred to, at the same time as explaining the key policy assurance around the worker's identity. Four of the policies scored highly in this category, nine had a satisfactory rating and one had a poor rating.

g. Access to independent advice

To score highly here, a policy will address how an individual can obtain independent advice, and list relevant bodies, such as, PCaW, trade unions and professional associations, along with their contact details. The majority of the policies reviewed contained information about advice services including PCaW. In this category, 12 policies scored an excellent rating, and three satisfactory. The latter rating was applicable where only one source of external advice is referred to.

h. Options for whistleblowing to external bodies (prescribed persons)

An excellent rating will be achieved by policies which include external sources for raising a concern, including a comprehensive list of regulatory and oversight bodies relevant to the organisations and discussion on wider disclosures and the risks involved. The majority of the policies reviewed included reference to external bodies, but surprisingly many did not refer to the relevant healthcare regulators for Northern Ireland, RQIA and the Northern Ireland Social Care Council (NISCC), as organisations prescribed in the Public Interest Disclosure Order to which a protected disclosure may be made. Eleven policies scored an excellent rating in this category and four were satisfactory (usually because key regulators were not mentioned).

2.3 Staff Surveys

During the planning stage of the review, trust representatives reported that a staff survey specifically in relation to whistleblowing arrangements had been carried out in the Southern Health and Social Care Trust (Southern Trust). A decision was taken to carry out a similar survey in the other Arm's Length Bodies, as part of the RQIA review.

Subsequently, a questionnaire was issued to all staff from Arm's Length Bodies, via Survey Monkey, based on the Southern Trust questionnaire. The process was not repeated in the Southern Trust, as they had agreed to allow their results to be included in the final report. The regional HSC survey, which contained a number of questions related to whistleblowing, had just been conducted prior to the RQIA review.

3085 staff completed the RQIA questionnaire and a breakdown of numbers per organisation[30] is shown in the Table 1 below.

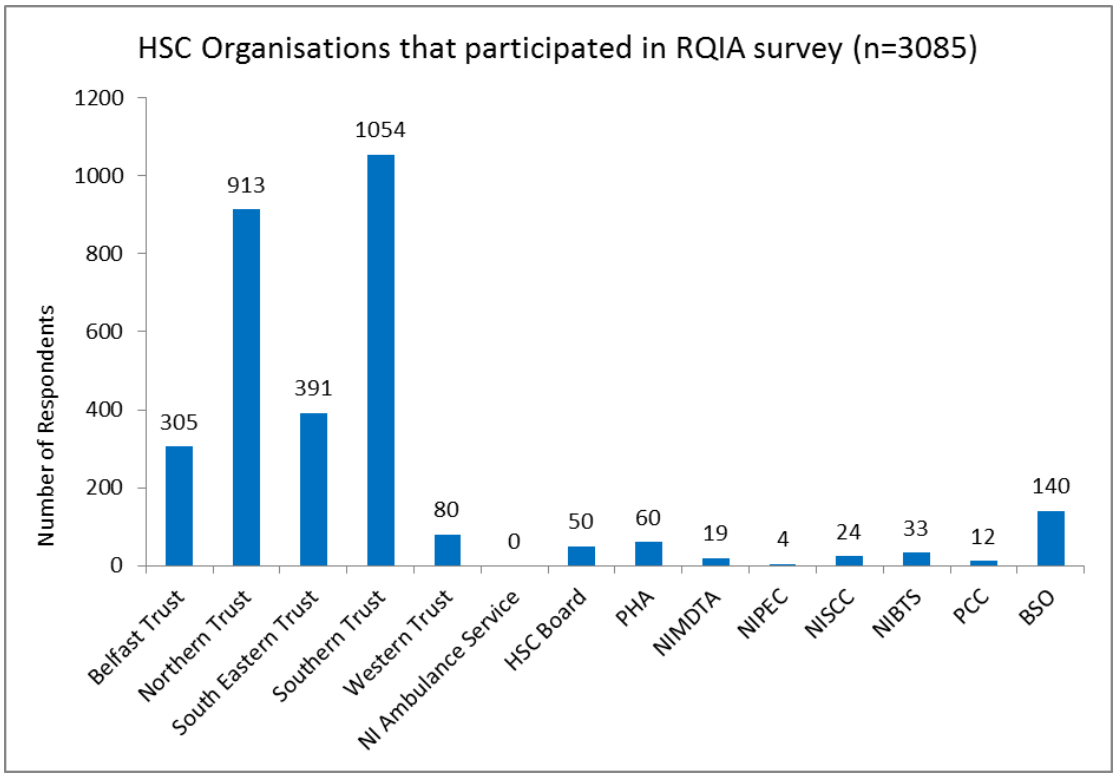

Table 1 – Number of responses per organisation

The RQIA questionnaire asked a number of questions that were similar to those asked by the regional HSC survey; however, the RQIA questionnaire allowed staff to enter freetext in order to explain the reasons, if any, as to why they had given a particular answer.

2559 (82.9%) respondents were aware that their organisation had a whistleblowing policy in place that provided guidance on how to raise a concern. However, only 1709 (55.4%) had confidence that their organisation would carry out a robust investigation of any concern they might raise.

Staff were asked if they would feel comfortable raising a concern with a senior manager/director in their organisation.

[30] It was reported by the Northern Ireland Ambulance Service that due to an administrative oversight, the survey was not distributed to their staff.

1632 (52.5%) answered yes to this question. A number of reasons were given as to why those who answered no would not feel comfortable. A summary of these responses included:

- afraid of the consequences
- afraid of repercussions
- afraid to be seen/labelled as a trouble maker
- afraid of harassment, victimisation and bullying
- fear of intimidation
- fear of reprisal
- fear of being isolated
- fear of losing job
- impact on career development and promotion
- lack of support and protection
- lack of confidentiality
- concerns were ignored
- raised concern before and it was ignored
- seen how cases were handled in the past
- don't have confidence in the process or management to deal with the concern appropriately

1553 (50.34%) respondents felt they would be more likely to raise a concern using a web based system that guaranteed anonymity.

841 (27.3%) respondents had experience of raising a concern within their organisation. The majority of those (681) had raised the concern with their line manager. 572 (68%) had not referred to the organisation's whistleblowing policy and the majority 745 (88.6%) had not raised the concern anonymously.

477 (56.7%) of those who had raised a concern felt that the concern had not been dealt with appropriately. The reasons given by respondents as to why they felt their concern had not been dealt with appropriately were:

- concern was ignored or not investigated
- poor investigation
- the concern was covered up
- the issue was put on hold, but never revisited
- got punished for raising the concern
- nothing happened/changed, and the issue persists
- issues still ongoing
- never got any feedback
- don't know the outcome

Of the 841 staff who had raised a concern, 372 (44.2%) considered that they had suffered detriment as a result of raising that concern. The key areas where staff believe they suffered detriment as a result of raising a concern:

- no action was taken and the person continues to do what they were doing
- person got moved or was transferred after raising concern

- disciplined for raising concern
- career has suffered - got overlooked for jobs and promotion
- financially worse off - fighting the case, impact on salary and pension
- damage to reputation
- was isolated/ignored by colleagues
- got bullied at work
- suffered from stress
- victimised after raising concern
- health has suffered - emotionally and physically

However, the majority – 627 (74.6%) reported that they would be very likely or likely to again raise a concern if they suspected wrondoing which is a positive result, showing that staff understand the importance of raising concerns.

Staff were also asked a number of questions specifically regarding fraud. The vast majority were aware that fraud falls within the scope of whistleblowing, were aware of a fraud policy within their organisation and would feel comfortable raising a concern regarding fraud with a senior manager/director within their organisation.

Finally staff were asked what would have improved the experience for them. The key points staff rasied were:

- a dedicated liaison person as a contact
- support from management
- counselling and support
- being listened to
- professional respect
- confidentiality
- the concerns being taken seriously
- formal process
- assurance that something will get done/ investigated
- having the whole process completed quicker
- a robust investigation
- a more open and transparent process
- appropriate action
- honesty from people involved
- feedback on the outcome
- a fair outcome

A regional staff survey was conducted in all HSC organisations in Northern Ireland from October to December 2015. This was conducted prior to the RQIA review and its questionnaire contained a number of questions regarding whistleblowing/raising concerns. The relevant questions were as follows:

- Are you aware of your organisation's policy and process for raising concerns about negligence or wrongdoing?
- Would you have the confidence to speak up within your organisation and raise concerns if you had cause to do so?

- Do you have confidence that your organisation would appropriately handle the investigation of any concerns raised?
- Are you aware of your organisation's whistleblowing process?
- Do you understand your responsibility under your organisation's whistleblowing process?

All organisations surveyed a full census of staff, with sample sizes ranging from 19 to 22,567. The overall number of staff surveyed was 70,213. 17,798 completed questionnaires were returned from this sample, which is a response rate of 26%. The key results from the regional survey were:

- 88% of staff reported that they are aware of their organisation's policy and process for raising concerns about negligence or wrongdoing
- 80% of staff reported that they would be confident to speak up and raise concerns if they had cause to
- 65% of staff reported that their organisation would appropriately handle the investigation that resulted
- 81% of staff reported that they are aware of their organisation's whistleblowing process
- 79% of staff reported that they understood their responsibility under their organisation's whistleblowing policy

Although the results from the HSC survey presented a positive reflection of whistleblowing, the review team was concerned that 35% of staff who responded were not confident that their organisation would appropriately handle the investigation of any concerns raised.

2.4 Focus Groups

As part of the review, staff were engaged in a series of focus groups and one-to-one appointments across all of the organisations involved in the review. The aim of these sessions was to determine staff perception and knowledge of, as well as trust and confidence in, their respective organisation's whistleblowing arrangements.

PCaW was commissioned to undertake this part of the review, in conjunction with RQIA staff. It was considered that as an organisation, they brought the necessary expertise, as their advice line has advised over 20,000 whistleblowers to date. This gives them a unique insight into the problems workers regularly face, when trying to raise a whistleblowing concern and when seeking action in relation to the issue raised. It was also considered that staff might raise a concern with them more readily than they would with RQIA alone.

Methodology

Over a four week period, 13 organisations were involved in the focus groups, with 368 individuals from a cross section of different staff groups participating in sessions.

This is a small number compared to the total number of staff working in health and social care. However, the review teams consider that the feedback provided a fair representation of staff understanding of the existence, operation and accessibility of whistleblowing arrangements across the sector.

Due to the size of the task (60,000 staff across the 14 organisations), it was not practical for PCaW to meet with every organisation. For several of the smaller Arm's Length Bodies, focus groups were undertaken solely by representatives from RQIA. For the larger Arm's Length Bodies, such as the trusts, PCaW facilitated the focus groups with RQIA in attendance. Within the trusts, focus group sessions were held at several locations. Following a low turn-out at one of the health trusts visited, repeat sessions were again undertaken solely by RQIA staff.

All focus group sessions were structured around a series of basic questions, intended to elicit discussion and thought on the broad themes of the engagement, i.e. perception, understanding, trust and confidence. However, these questions were only the starting point for an informal group discussion, and in most instances the conversation took unique, interesting and sometimes disparate turns. Nevertheless, across sessions, several consistent and strong themes emerged and these are detailed in the body of this report.

In addition to the focus groups, at each site an opportunity was provided for those with experience of whistleblowing to speak to PCaW staff. These experiences have been referenced where appropriate in the main body of this report, but also form the content of Appendix 3, where a number of anonymised case studies focusing on the experience of those involved have been included. A number of case studies were excluded, as individuals were seeking ongoing advice about their particular circumstances and the sensitive nature of such cases prevents inclusion of even an anonymised version of events. The inclusion of the case studies in Appendix 3 were discussed with those involved, and their permission was granted for inclusion in this report.

During the focus group sessions, all staff who attended were asked to write down suggestions on how whistleblowing arrangements could be improved. These suggestions have been collated and are set out in Appendix 2.

Themes and Perceptions

The almost universal perception was that the term whistleblowing was viewed as being a negative label for the process of raising a concern.

The terms 'touting', 'squealing' and 'telling tales' were regularly cited as being linked to the term 'whistleblowing' and for many, these appeared to be inextricably linked to the history of the Troubles in Northern Ireland. Indeed, this theme, while not always explicitly expressed, seemed to touch upon various aspects of the general discussion around whistleblowing. From an outside perspective, this period in Northern Ireland's history seemed to permeate a culture of silence from community level through to the workplace with respect to questioning wrongdoing.

It should be noted, that in no sessions did the question of religious or political affiliation get raised; the relevant issue appeared to be how you were seen to interact with authority in a generalised sense.

It was notable that there was a clear trend with younger workers, who may have been less influenced by this political history, to have slightly more positive views surrounding the issue. Several of this group made comments to the effect that they believed their peers saw whistleblowing/raising concerns for what it was; a necessary ingredient in carrying out your job. Clinicians (especially representatives from nursing and pharmacy) were on the whole, more positive in relation to raising concerns, and a large part of this seemed to be from recent pushes towards a more 'open and honest culture' within their teams. This also appeared to be closely linked to the incident reporting and quality improvement agenda in several of the organisations involved. It was identified that in the medical records and pharmacy departments, which were often held accountable for issues, such as, missing charts or wrong prescriptions, staff had a clearer understanding of the need and process for raising concerns.

There was, however, an interesting nuance to these views. While there was almost universal agreement that whistleblowing was seen negatively, only a small proportion of participants were prepared to ascribe those views to themselves. In other words, they saw whistleblowing as 'doing the right thing', but believed others would see it in a negative light and too often the individual will be seen to be part of the problem. Perhaps this is in part because individuals may have felt uncomfortable expressing a view they felt would paint them in a negative light (i.e. not doing anything about a serious issue they had witnessed). It was also possible that those who attended sessions may not have been a fully representative subset of the work force. Nevertheless, it seemed that there was a clear disjoint between how whistleblowers were actually seen and how they were perceived to be seen.

There was a strong view that the act of whistleblowing resulted in negative consequences for the whistleblower.

The most prevalent negative outcome discussed was that of blacklisting, or general stalling of career prospects. Many participants seemed resigned to the fact that this was in many ways a natural and expected outcome of becoming known as a whistleblower. Equally, however, there was also a fear of retribution, although in many instances it was assumed that this would come from colleagues more than management. In one group, a threat to physical safety to both the individual and their family was discussed; however, this was very much a fringe view.

In several sessions, it was commented on how this fearful view was to a large degree driven by the media's portrayal of whistleblowers' fortunes. Participants referenced how the only stories published were those where the whistleblower had suffered personally and that this in turn built an image that all whistleblowing ended negatively.

In fact, as most participants had no personal or direct experience of whistleblowing, it may well be that the only factor currently driving such a perception of negative outcomes is the media. Where individuals had been involved in whistleblowing (see Appendix 3), the overriding experience was negative, whether as the individual who had reported an issue, or as an accused. There were, however, a small number of participants who had been involved in the investigation or oversight of the whistleblowing process and these individuals had more positive views and better overall understanding of the process.

Understanding of the term 'whistleblowing' was inconsistent, confused and in many cases, wrong.

One of the strongest themes to emerge from the sessions was the almost universal confusion as to what the term 'whistleblowing' referred to. Almost all participants understood it to be some form of raising concerns but the 'how/where/what' varied hugely. There were almost as many variations and combinations as there were groups; however, certain common factors were consistently mentioned during the discussions.

Many participants considered that whistleblowing was only used if the issue being raised was very serious. Others considered that it was when the concern was being raised outside of the organisation (perhaps to the media), and some believed it was when the concern was raised anonymously. A less widespread but still prevalent understanding was that whistleblowing referred to those incidents of reporting which were likely to result in a specific individual being put under scrutiny. Additionally, another common view was that whistleblowing was an option of last resort; a means of raising concerns when all other routes had been tried. Many staff thought that the starting point for whistleblowing would be with a line manager. When asked, very few individuals knew what was in their organisation's policy itself and only one participant had received specific training.

This lack of conviction in what whistleblowing might refer to manifested itself sharply in participants' conception of how whistleblowing fitted in with existing reporting procedures, which is to say what circumstances required whistleblowing as opposed to recording on Datix[31] or serious adverse incident reports[32]. This was of particular interest given that, while most individuals had difficulty differentiating between reporting streams, whistleblowing was seen negatively whereas everything else was just part of the job. This felt like a very significant area of confusion for the participants. Most staff were unable to conceptualise when or how a whistleblowing policy might be invoked.

[31] Datix is the leading supplier of patient safety software for healthcare risk management, incident and adverse event reporting. The software is widely used within both public and private healthcare organisations around the world. - http://www.datix.co.uk/

[32] This sort of confusion was less prevalent in those participants based in non-clinical environments given that they very rarely used the clinical reporting lines. That being said, generally understanding of whistleblowing was actually better in clinical groups as opposed to non-clinical.

Another common, although less pervasive area of confusion, was the difference between grievances and whistleblowing. Even those participants, who claimed to have a better understanding of the distinction, on further discussion, rarely had any confidence in their assertions.

Although there is no specific and universal definition of the term whistleblowing, especially in a complex medical environment where it must interact with multiple other reporting streams, what is important is a degree of consistency in understanding across the workforce. When this misunderstanding of the term is combined with the background of historic influences and the sense of potential negative outcomes, it seems that for the most part, staff would not consider using a whistleblowing process.

It was the view of many of the staff groups that whistleblowing was often seen as a process intended as a safety net for when the usual reporting systems do not work. Without more effort in the communication process, it would seem that there is a dangerous tendency towards a culture of silence. This was despite the view that to report risk or wrongdoing was the right thing to do. This may present a risk that where existing reporting structures do not capture a concern, it may be lost and harm to patients may potentially ensue.

Throughout the sessions, a popular suggestion was to do away with the term 'whistleblowing' given both the confusion and negativity that surrounds it. Unfortunately language does not work like this, and removing a word from internal publications will not stop the public and the media continuing to use it. The risk here is that you entrench negative views towards some of the rarer, but often entirely appropriate, ways of raising concerns. Some participants saw the value in incorporating whistleblowing into the wider family of raising concerns rather than not using it at all.

Some of the group discussions centred on the perception that one of the barriers to raising concerns might be that the issue raised would not be addressed. This results in a sense of futility, therefore discouraging the individual from raising a concern in the first place. There were mixed views expressed around this theme. In many of the discussions about raising an issue with an immediate line manager, there was a sense that the issue would be addressed; however, it was less clear that raising the issue further up the line management chain would be as easy. In a minority of the discussions, the difficulties and problems surrounding other reporting mechanisms, such as Datix, and confusion where raising concerns fits within the system, were mentioned as a more fundamental problem with safety reporting mechanisms in the health service generally.

Knowledge

Although rarely explicitly stated, it was clear that whistleblowing policies were misunderstood and a lack of knowledge about the content of such polices was almost universal.

Almost all participants knew that their trust had a whistleblowing policy and the vast majority could find it if needed. However, very few participants had actually ever read it, knew the content of it, or understood it.

This appeared to be part of a wider trend with respect to policies. A consistent message was that the overbearing number of policies made it impractical to read them all and so policies were only accessed when they were needed. For the majority of participants, this was a satisfactory state of events; however, several groups recognised that this approach presented a problem if the policy was intended to convey messages relevant at a point before things had gone wrong.

Of those that had read the policy, all but a negligibly small number belonged to the following groups:

- their job role meant they had frequent contact with policies
- they had been in a situation in which they believed the policy applied
- they had read it in preparation for the focus group

Of those that had not seen the policy, there was usually little idea of what it might contain. Commonly, it was suggested that the policy allowed a worker to contact someone higher in the line management chain where their concerns had not been dealt with by direct management. Some participants suggested that the policy might contain a list of individuals who could be approached with concerns, although there was generally little idea how this might extend outside of the line management chain.

Where a policy only fulfils its function when actively sought out by workers, it naturally follows that it does not serve that function if individuals are unaware of when it might be relevant to their situation. This is obviously the case with respect to the widespread confusion as to what whistleblowing refers to (see above) but also relevant where there is little conception of what the policy might contain. Most of the organisations' policies contain commitments about protection of whistleblowers, options for raising concerns outside of line management and assurances that their concerns will be properly investigated. These messages will be of no use to staff who make their decisions not to access the policy because they are: scared of the consequences; do not consider their line manager an appropriate contact; and do not believe their views will be valued.

It is of note that only one individual advised of receiving any training on the issue of whistleblowing. This was provided by the Royal College of Nursing as part of an external training resource, as opposed to being part of any in-house training module.

Outside of the line management chain, where experiences were generally positive, knowledge of other forums for raising concerns was sparse.

Most participants mentioned their line manager as the natural starting point for raising a concern they may have. Several groups touched upon the challenge involved in escalating an issue to the line manager's line manager. This was seen to be problematic as the senior manager may well have a personal relationship with the line manager. Indeed, multiple participants told us of circumstances where an issue that had been escalated had been passed straight back down to the line manager, rendering the escalation beyond the line manager not only pointless, but also problematic and potentially confrontational. When asked, several line managers involved in the focus groups had negative attitudes toward the concept of being circumvented by those staff members they manage. Lack of knowledge of the routes open to staff through whistleblowing arrangements was as prevalent among managers as it was with those with no management responsibilities.

Most commonly, staff referred to Human Resources (HR) as an alternative to the management line. A point of contact in Risk and Governance was also suggested, and when put forward as an alternative; some participants saw value in this idea. Likewise a role with independence was often suggested by participants, such as a Board member or a Non-Executive Director, but only with some prompting beforehand.

Many participants mentioned their union as a possible alternative for raising concerns, although in discussion it was recognised that unions may not be able to deal with the issue themselves. In the course of a couple of sessions, union representatives commented on how the unions were perhaps poorly placed to deal with concerns raised with them. There may be a conflict of interest relating to those accused in some matters, as well as the fact that they would be looking to protect the worker, not deal with the concern raised.

It was particularly surprising how little the regulators within the sector, RQIA and NISCC, were proposed during discussions as a forum for concerns. Even where they were cited as a body that could be approached in the organisation's whistleblowing policy, there was generally confusion as to how this might be achieved. This seemed to be a distinct gap in reporting structures.

There was a strong and consistent message from participants that the media had little role to play in getting concerns dealt with effectively. A number of media shows and personalities were the subject of particular comment and criticism. Several participants commented on how the media's agenda of entertainment rarely aligned with the whistleblower's aim to get problems solved, and that this often resulted in a lack of responsibility and proportionality when handling the issue.

Although the topic was only covered in a small number of sessions, it appeared as if there was a complete lack of knowledge that there was legislation protecting whistleblowers from detriment, or any legal element to the protection of those who raise concerns within the workplace. Hence there was a very low awareness of the Public Interest Disclosure Order 1998.

Trust and Confidence

The only consistent message from the groups on how whistleblowers could be protected from negative consequences was by the protection of their identity.

Generally, the only way that participants felt they could be protected, was by their identity not being associated with the concern. There was confusion around the difference between a concern being raised anonymously (where no-one knows who it is that has provided the information) and confidentially (where one or more individuals know the identity of the whistleblower but protects that identity during the course of the investigation).

Views were mixed on whether confidentiality would be respected by those handling the concern. One prominent view was that confidentiality in the Northern Ireland's health service didn't really exist; communities were too closed and interlinked. Several participants commented on how multiple members of a family might commonly work in the same unit or the same trust, and so the likelihood of the 'rumour mill' operating to uncover the identity of the person who raised the concern, was considered to be very high.

For many, the option of confidentiality was seen to be a desirable element of protection for staff that raised a concern; they commented on how they had no reason to believe that managers wouldn't protect their confidence in these situations.

It was stated consistently from those tasked with handling investigations, that in most instances, it was almost impossible to investigate anonymous concerns. Additionally, those involved in a number of investigations advised that anonymous concerns can be extremely damaging to team morale.

From this perspective, it appeared that raising concerns anonymously was appealing from a protection point of view, but it was not generally an effective way of getting problems dealt with. Furthermore, one individual who contacted PCaW talked passionately about the effect that anonymous concerns can have on the wider workforce and the potential for them to be used vexatiously. This participant described how a series of anonymous disclosures had bred a culture of paranoia and had eroded staff confidence.

In response to how whistleblowers can be protected, participants rarely suggested that managers have a role to play.

Very few participants put forward the idea that the actions of management played a role in protecting whistleblowers from victimisation. That said, once the idea was put to groups, individuals generally agreed that managers could directly support the whistleblower. Generally, it was suggested that the best way this could be achieved was by being seen to take firm action against those who victimised whistleblowers, rather than actually being able to stop the victimisation in the first place.

Many participants commented on how this no tolerance approach needed to extend to management, especially in cases where no action had been taken by them after a concern had been raised.

While staff having confidence that their concerns will be dealt with is an important piece of the puzzle, several groups commented on how it was also important to have confidence that the receiver of concerns would not overreact. This formed the basis of some discussion in several of the groups interviewed, particularly in relation to minor issues raised anonymously. It was felt that there could sometimes be a lack of proportionality when the whistleblowing policy had been invoked, and those accused in these circumstances were subsequently not sufficiently supported. This was a theme that was raised at several of the groups and at different organisations. There is clearly a need for proportionality and fairness for those accused of wrongdoing, as well as for the individual raising the concern.

Participants regularly commented on how the most common aim of the whistleblower was to have the concern addressed and not for there to be serious repercussions for staff or the unit. A fear of unnecessary repercussions was highlighted as a factor which may prevent people from highlighting concerns.

Generally participants were confident that if they raised serious issues with their managers then they would be dealt with.

In some groups, however, there was an understanding that this might not be so true of concerns that were linked to funding, such as understaffing.

Several non-senior auxiliary staff that attended the focus groups, expressed doubts as to whether they would be listened to if they raised concerns. This could be a missed opportunity, given that these staff are very much the eyes and the ears of the organisations, and will often be the first to observe any problems.

Conclusions

From the outcomes highlighted in this section of the report: the combination of a lack of understanding around what is contained within whistleblowing policies; a fear of negative repercussions; and a sense that raising a concern may be futile; do not facilitate effective whistleblowing arrangements.

The review team considers that as a minimum, training or awareness raising sessions should be developed to improve staff awareness and understanding of the whistleblowing process, together with communication focusing on how the whistleblowing policy is more than a safety net for other every day reporting mechanisms. Furthermore, it should be considered whether work can be done at an organisational level, to make potential whistleblowers feel supported and protected, reducing the reliance on anonymity for safety.

It is to be hoped that such work may go some way to normalising the whistleblowing process and overcoming the existing staff perceptions and misunderstanding of whistleblowing.

2.5 Meetings with Senior Teams

As part of the review, the review team met with senior managers from each of the organisations, who had responsibility for oversight of whistleblowing arrangements. The discussions focused on the operation of their respective whistleblowing arrangements and what could improve whistleblowing across health and social care. The discussions were very constructive and form the basis of the conclusion section of this report.

2.6 Stakeholder Event

In April 2016, as part of the review methodology, RQIA hosted a stakeholder event which was themed 'Raising Concern, Raising Standards'. It provided an opportunity for a range of staff working across different HSC organisations to discuss the initial findings from the review, identify arrangements for whistleblowing in other jurisdictions and discuss potential next steps that may be included in the final report.

During the event, one reviewer shared their own personal experience of being involved in a whistleblowing case; a representative from the Scottish Government outlined the development and current arrangements for raising concerns in Scotland; PCaW presented the initial findings in relation to the assessment of the whistleblowing policies and the staff engagement; finally, the review team presented the initial findings from the review.

Participants discussed the findings with members of the review team and were also involved in group discussions regarding next steps, in relation to:

- changing culture within organisations
- arrangements for recording and reporting concerns
- future oversight arrangements

Changing Culture within Organisations

Participants accepted there was a need to change the culture within organisations in relation to raising concerns. As the organisations were fundamentally different, a single solution would not fit. Some participants proposed that the equality and diversity agenda may be a suitable mechanism to facilitate this.

It was acknowledged that further clarity on raising concerns needs to be provided for staff. This could be achieved through improved communication about raising concerns and training for all staff within the organisations.

Participants suggested that more advertising and promotion of raising concerns was needed, such as, posters or campaigns to increase awareness. Encouragement and praise would also be required to demonstrate the positive outcomes of raising concerns. This should be supported by a more visible demonstration of management's commitment to raising concerns.

Participants all understood that changing organisational culture was a huge task, and would not be achieved immediately. However, implementing some of the areas they proposed would be an initial step in the right direction.

Arrangements for Recording and Reporting Concerns

Participants felt this was an area that could not be solved in a single workshop, due to its complexity. However, they proposed many very sensible and useful suggestions.

Putting in place appropriate mechanisms for recording and reporting was acknowledged as a task which would require input from all stakeholders. Given the size and complexity of the different organisations, it was recognised that the mechanism may be different for each organisation.

In relation to what, when and how often things should be recorded and reported, participants considered that individual organisations and stakeholders would have to determine how this was taken forward. Key areas for further discussion and development were proposed, such as:

- formal or informal reporting and the exceptions
- differentiating between concerns and other issues, such as, grievances or complaints
- methods of raising concerns and how these are captured
- internal or external reporting and the mechanisms to achieve this
- lessons that could be learned from the concerns raised and how this could be shared

Participants highlighted that there are many existing mechanisms for recording and reporting activities throughout all organisations. Rather than invent something new, existing mechanisms should be considered as possible ways to support recording and reporting of concerns. Learning arising from appropriate recording and reporting of concerns should be shared throughout the organisations.

Future Oversight Arrangements

During the stakeholder event, presenters outlined the details of the oversight arrangements for raising concerns in England and Scotland. Participants then discussed the merits of the different arrangements within the context of Northern Ireland.

In conclusion, it was acknowledged that oversight arrangements for whistleblowing already exist in Northern Ireland, through DoH. Participants considered that some clarity on any proposed oversight arrangements was required, to determine what they were designed to achieve. It was proposed that rather than setting up new bodies or developing new arrangements, existing arrangements should be revised to ensure they provide appropriate outcomes in relation to raising concerns.

Participants acknowledged that much work was required in relation to setting up appropriate arrangements and mechanisms for raising concerns, which would require input from all stakeholders.

Section 3 – Conclusions and Recommendations

3.1 Overall Conclusions

Policy Development

Throughout the review, a recurring theme was the use of the term whistleblowing. Whistleblowing was universally seen as a very negative term, which was not helped by the media's portrayal of cases of whistleblowers. Focus groups highlighted that the only stories published seemed to be those where the whistleblower had suffered personally, creating an image that all whistleblowing ended negatively. There was also confusion as to what the term actually referred to; some staff considered that it was only whistleblowing if the issue being raised was very serious or was being raised outside the organisation. Other staff considered that whistleblowing was about something that involved criminal wrongdoing such as fraud, rather than being about a patient safety concern. There was also confusion as to where whistleblowing fitted into existing reporting procedures such as incident reporting. Focus group participants saw incident reporting as just part of their job but were not really aware as to when their organisation's whistleblowing policy might be used.

In his review of whistleblowing in the NHS, Freedom to Speak Up, Sir Robert Francis gave consideration to recommending that the term whistleblower should be dropped. Even though there were reservations about its continuing use, he had been persuaded that the term was now so widely used that removing it would not succeed. PCaW considered that removing a word from internal publications would not stop the public and the media from using it. There is a danger that the word may shift its meaning to denote only those rarer forms of raising concerns, which may only further entrench the stigma towards whistleblowing.

The review team is aware that removing a single word from the vocabulary of HSC policy will not automatically lead to an improved culture of raising concerns. However, they consider that in light of the overwhelming negative view of the term whistleblowing and the fact that it might be actively preventing proper reporting of the full range of concerns, it should not be the main title of any policy in relation to raising concerns, as this immediately takes the reader to the end point of what should be a spectrum of raising concerns.

All organisations subject to the review had a whistleblowing policy in place. Although a number had been updated, it seemed that most policies were based on guidance provided by DHSSPS in February 2009. In its review of existing HSC policies, PCaW considered that a number were overly legalistic and tended to use language associated with handling of complaints or grievances, which is not conducive to encouraging staff to use the policy.

The review team considers that whistleblowing is only one step along a continuum or spectrum of raising concerns and may be seen as the end point of raising a concern. Concerns are raised and dealt with daily and most may be resolved quickly and informally. However, for more serious concerns, there needs to be a more formal process. The process needs to provide clarity to the person raising the concern as to what will actually happen next, to how they will be kept informed of progress, and eventually how they will be informed of the outcome as a result of their raising a concern. Any policy should reflect the reporting of both formal and informal concerns and should culminate in providing advice about other organisations a member of staff may go to when they feel it is appropriate. The policy should also easily distinguish between raising concerns and incident reporting and act as a signpost as to where concerns would be best addressed.

The review team considers that the first step in encouraging the normalisation of raising concerns is the development of a model policy for Northern Ireland that reflects current thinking. The policy should consider the negative connotations associated with the term whistleblowing and take account of the whistleblowing code of practice and recent policies such as the Department of Finance and Personnel Whistleblowing Policy[33] and the new policy – Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS, which was developed following the Robert Francis Review[34].

The review team considered feedback that indicated that a one size does not fit all and one policy would therefore not be the best way forward; however, this approach has already been taken in both England and Scotland and the review team considered this would be the best approach for Northern Ireland. It should be emphasised that all organisations could individualise the policy to take account of their particular situation.

The review team has made recommendations for improvement to the arrangements to whistleblowing across health and social care. The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report:

- Priority 1 - completed within 6 months of publication of report
- Priority 2 - completed within 12 months of publication of report
- Priority 3 - completed within 18 months of publication of report

Recommendation 1	**Priority 1**
The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	

[33] Department of Finance and Personnel – April 2011 - https://www.dfpni.gov.uk/publications/dfp-whistleblowing-policy
[34] Freedom to speak up: raising concerns (whistleblowing) policy for the NHS - April 2016 - https://improvement.nhs.uk/uploads/documents/whistleblowing_policy_30march.pdf

Effective Leadership

All organisations provided evidence of having extensive governance arrangements in place, with some demonstrating good integration with quality improvement and organisational learning programmes.

There was an awareness of the need to create an open and honest culture, and many organisations demonstrated their understanding of the need for visible leadership. A number of methods were used to achieve this, with senior management and board member walk rounds being the most popular. Other methods included staff open forums where senior staff were available to listen to staff concerns. In one organisation these concerns were logged in order to try to facilitate feedback. This was considered to be a very positive development which also led to better feedback to those who raised a concern.

A learning and development steering group has been developed in an organisation, chaired by a non-executive board member, which discusses concerns and uses scenarios to elicit learning which is then passed through the organisation.

The review team considered that these were extremely positive steps but that further development in this area was necessary. The review team also considered that it was important to assess the effectiveness of any developments in this area.

Recommendation 2	**Priority 1**
All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	

Reporting to organisational boards is also an important step in assuring that raising concerns is seen as an integral piece of organisational governance. It was unclear to the review team that this was happening to any great extent and it seemed to be very much left to individual judgement as to what was or was not reported.

The very extreme examples of what would ordinarily be termed whistleblowing would be brought to boards, but the review team considered that the principle of normalising raising of concerns had not yet become part of day to day practice.

Concerns that had not reached a particular threshold were not being recorded or passed up the chain to organisational boards. However, there were areas of good practice where service users and employees were offered the opportunity to attend board meetings to report on their experiences.

To ensure further development in this area, the review team considered that a non-executive board member should be appointed to have responsibility for overseeing the culture of raising concerns within each organisation.

Recommendation 3	**Priority 1**
Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	

Staff Training and Awareness

Policy development and leadership are important steps in development of a culture that openly normalises the raising of concerns, making it part of day to day business. Staff awareness and ability to understand and be comfortable with the process of raising a concern are also vital components of any system.

On the positive side, both the HSC and RQIA surveys indicated that a large percentage of staff knew their organisation had a whistleblowing policy in place. The HSC survey also reported that the majority of staff (80%) would be confident to speak up and raise a concern. The majority of staff responding to the RQIA survey would feel comfortable in approaching their line manager to raise a concern (80.9%).

However, a lesser percentage (65%) of respondents to the HSC survey indicated that they felt their organisation would handle their concern appropriately. 55.4% of staff who responded to the RQIA survey had confidence that their organisation would carry out a robust investigation of any concern they might raise and only 52.5% would feel comfortable reporting a concern to a senior member of their organisation. This identifies that approximately one third of staff responding to the HSC survey feel their organisation would not handle their concern appropriately.

841 members of staff who had raised a concern within their organisation responded to the RQIA survey. 477 (56%) of these respondents considered that their concern had not been dealt with appropriately and 572 (68%) had not referred to the organisation's whistleblowing policy. 372 (44.2%) considered that they had suffered detriment as a result of raising that concern.

While the survey numbers are small, the results indicate that although staff are aware of whistleblowing policy and procedure, a number are not confident that if they raised a concern it would be dealt with appropriately. Of those who had raised a concern, over half felt their concern had not been dealt with appropriately.

The majority of staff attending focus groups were also aware of the existence of a whistleblowing policy but few were aware of what it contained. However, once again staff felt confident about approaching their line manager.

It was noted that several non-senior auxiliary staff expressed doubt as to whether they would be listened to if they raised concerns.

It was identified that many staff had a limited understanding of whistleblowing and the associated process for raising a concern. If advice and support was readily available to them, this may have increased the number of concerns raised.

A whistleblowing helpline has been established by the Department of Health in England. The helpline is provided free of charge, staffed by specially trained advisors and provides advice to individuals at all stages of the spectrum of raising concerns, from those thinking about speaking up to those who have suffered as a result.

On 2 April 2013, The Scottish Government, in its response to the Francis Report, launched The National Confidential Alert Line for NHS Scotland. This helpline was managed by PCaW, and was designed to provide a safe space where staff could raise concerns about patient safety and malpractice. Staff could also obtain advice and support if they felt they had been victimised as a result of whistleblowing. Following what was considered to be a successful pilot, the Confidential Alert Line was continued after receiving further funding.

To demonstrate a commitment in relation to raising concerns within Northern Ireland, the review team considered that DoH should establish a pilot confidential helpline. The helpline should provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland.

In line with the Scottish approach, the helpline could be run as a pilot for a period of at least one year, with an evaluation prior to the pilot finishing to decide whether or not to continue with it. Data from the calls should be used in the evaluation and also to support learning.

Recommendation 4	**Priority 1**
The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	

All senior staff reported that the whistleblowing policy formed part of a staff induction process. The policy was then made available on organisational intranets. Other methods of raising staff awareness included a Raising Concerns Booklet, staff notice boards, posters and screensavers on employee computers.

One organisation is currently developing an e-learning package for staff, and another had developed a training package to be delivered across middle management which will place an emphasis on “ringing bells” rather than “blowing whistles”, in order to decrease the negativity around being seen as a whistleblower. These were seen by the review team as positive developments.

However, beyond this no further training or awareness sessions were carried out and no organisation tested staff awareness on an ongoing basis. It was also unclear as to the level of training provided for line managers and all other managers with responsibilities outlined in whistleblowing policies.

The review team considered that for a system of raising concerns to work effectively, awareness training needed to be available for staff in how to raise concerns but also in relation as to how raising a concern fits in the overall governance process, including incident reporting complaints etc. For operational staff, this could indeed be part of induction but needed to go further than just being made aware of the existence of a policy. Managers need to be provided with the competence and confidence to enable them to respond to and address concerns raised with them.

Specific training also needs to be available for all staff involved, including managers, in the operation of the process for raising concerns. The review team considered that following development of any new policy, awareness training and bespoke training in relation to raising concerns should be developed for staff. This work may involve utilising existing training resources or the development of new e-learning packages.

Recommendation 5	**Priority 2**
Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	

Recommendation 6	**Priority 2**
All managers should receive bespoke training in the operation of their policy for raising concerns.	

As well as the provision of training, assessing the effectiveness of any training provided is also important. One method of assessing staff awareness of raising concerns and the effectiveness of any training provided is through staff appraisal. Appraisal also provides an opportunity to emphasise to staff, the importance to the organisation of raising concerns. The review team discussed appraisal rates during meetings with senior teams.

Appraisal rates in the small organisations were mainly good; however, appraisal rates in the larger organisations varied between 42% and 80%. It is not uncommon for smaller organisations to have a higher appraisal rate than in the larger organisations; however, the review team considered that appraisal rates in some organisations were very low and efforts should be made to increase the uptake of staff appraisal.

Recommendation 7	**Priority 1**
All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	

Organisational Oversight

One of the recommendations of the Freedom to Speak Up review was in relation to where responsibility for the daily oversight of the process for raising concerns should be situated. In the majority of organisations in the United Kingdom, responsibility lies with the HR department. However, the Francis review questioned as to whether this was appropriate. HR may be seen as threatening, as it is the department that will take the lead in grievance processes and processes to deal with poor performance. The Francis report made the recommendation that:

"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".

A number of organisations reported that having whistleblowing under the responsibility of HR worked well for them, and saw no reason to change. Some of the smaller organisations may also see any change being difficult as a result of their size. There is logic, however, that if the raising and reporting of concerns becomes part of everyday culture, responsibility may best sit elsewhere within governance reporting structures. This would then allow HR departments to become more independent when it comes to any concern that required further investigation.

The review team does not feel that it can be prescriptive as to where responsibility is best placed, but would recommend that when a new policy is developed, consideration should be given as to where best responsibility for oversight sits.

Recommendation 8	**Priority 1**
All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	

Effective Feedback

One of the principles contained in the Whistleblowing Code of Practice is that a member of staff who has raised a concern should be told, where appropriate, the outcome of any investigation. The Freedom to Speak Up report also considered that feedback was an important part of the process.

The review team considered that any change in practice/procedure should take place at both an operational and an organisational level. The review team was told that organisations mostly did not record concerns and also did not feedback what action was taken as a result of raising a concern. That is not to say that there was no feedback at all, and several organisations described multiple feedback methods including newsletters, staff briefings and learning reports. One organisation, perhaps as a result of previous incidents, had a more developed culture of raising concerns, was reflecting these on risk registers and when resolved, feeding back to those involved in raising the concern.

Any method of feedback is to be supported, but feedback to individuals is essential. Using the mediums described did not emphasise that learning and any change in practice, was as a result of reporting a concern. The review team also considered this would be an important step towards normalising the raising of concerns.

Recommendation 9	**Priority 1**
All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	

Local Advocates

The Freedom to Speak Up report suggested that organisations develop local champions in relation to raising concerns. The functions of a local champion included:

- ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- intervene if there are any indications that the person who raised a concern is suffering any recriminations
- work with HR to address the culture in an organisation and tackle the obstacles to raising concerns

An example of the development of local champions is the appointment of advocates in relation to raising concerns in Guys & St Thomas' NHS Foundation Trust.

The role of an advocate in the trust is one of support for members of staff who wish to raise concerns and to help them to determine the most appropriate way for their concern to be dealt with. In their role profile, advocates "provide immediate support and signposting for staff members raising concerns, determining the best course of action and advising the staff member of their options. It is not envisaged that the Advocate would take on the concern but rather support the staff member to effectively raise their concern, where appropriate, or seek an alternative course of action."

The review team considered that the development of advocates at a number of levels, especially in larger organisations, may contribute to development of a more open culture in relation to raising concerns.

Recommendation 10	**Priority 2**
All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	

Independent Oversight

The Freedom to Speak Up review recommended that an Independent National Officer be appointed, with functions that include:

- reviewing the handling of concerns raised by NHS workers where there is cause for concern in order to identify failures to follow good practice
- advising the relevant NHS organisation, where any failure to follow good practice has been found, to take appropriate and proportionate action, or to recommend to the relevant systems regulator or oversight body that it makes a direction requiring such action
- acting as a support for Freedom to Speak Up Guardians
- offering good practice advice about handling concerns
- publishing reports on the activities of the office

The Scottish government has also committed to the development and establishment of an Independent National (Whistleblowing) Officer, to provide an independent and external review on the handling of whistleblowing cases.

The topic of whether or not Northern Ireland should have such an oversight body was discussed during a number of organisational meetings and also at the stakeholder event. The consensus of opinion seemed to be that due to the scale of the system in Northern Ireland, there was no need for such an appointment and the review team agreed with this point of view. However, the review team considered that there should be some ongoing oversight at an operational level as to whether processes for raising concerns were effective.

RQIA carries out reviews and inspections in acute hospitals, assessing them against the domains of safe, effective, compassionate care and well-led. The review team considered that progress in relation to normalisation of raising concerns may be included as part of the well-led domain of the RQIA regulatory process. This would provide assurance in the larger trusts, and DoH should consider how this could be taken forward in the smaller Arm's Length Bodies.

Recommendation 11	**Priority 1**
RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	

All organisations recognise that raising concerns is one essential element of an open and transparent culture. All organisations felt that they had an open and transparent culture but were unclear as to what evidence could be produced to substantiate this claim. All organisations quoted the results of the HSC survey and a number quoted having gained Investors in People as measures that all was well with the culture in their organisation. These are positive developments and not to be underestimated, but are quite high level measurements.

Evidence from this review suggests that while many staff do raise concerns, a significant minority do not, for a variety of reasons, including feeling that nothing will be done and fear of reprisal. The review team considered that most organisations had not effectively promoted raising concerns or looked for evidence of the effectiveness of their strategies.

Northern Ireland has a very low level of whistleblowing, and again, organisations used this as another measure of demonstrating that all is well. The lack of whistleblowing cases may indeed reflect that systems are working effectively; however, it may also be evidence that the system is not working at all. The reason for a very small number of cases may be that staff do not have confidence that there will be positive outcomes for them or their organisation, as a result of raising a concern.

What should be reported and recorded in terms of raising concerns was also the subject for much discussion during organisational visits and also during the stakeholder event. It is accepted that not every conversation that takes place between a line manager and a member of staff needs to be recorded; however, there must be a threshold beyond which a concern should at least be recorded in the system.

Identifying a threshold for recording concerns will enable better monitoring of trends and will help to normalise the raising of concerns, which could contribute to a more open and honest culture.

It would also:

- facilitate the process of feedback to staff who have raised a concern
- enable outcomes, in terms of change in practice, to be demonstrated

Such feedback has the added advantage of making staff feel valued and helps them to understand what they do actually matters. It again has to be emphasised that it is not the intention of this review to create yet another industry around reporting and recording of concerns.

Organisations already have strong governance processes in place and raising concerns should become part of normal day to day governance. Awareness raising for all staff and training for managers should provide them with the skills to assist with the process.

Due to the diverse nature of the organisations, it is very difficult to make specific recommendations aimed at developing an open and honest culture. This is something that organisations must develop themselves. Organisations must also identify ways of demonstrating that they are working towards developing such a culture that fits their particular circumstance. All organisations must also decide what level of recording and reporting they feel is appropriate for them. The review team considers that it is not acceptable for organisations to assume that a low level of raising concerns is positive. They must each 'test the silence' using a range of metrics and indicators to build a picture of the 'health' of individual directorates/divisions/departments. This will provide assurance as to whether the process of raising concerns is working well in their organisation.

The review team understands the difficulty in prioritising raising a concern/ whistleblowing when it is competing against a wide range of other priorities. It may be that there are low levels of concerns in Northern Ireland. However, if these small numbers are not treated appropriately, then many more staff will learn from this negative experience that it is better not to speak up.

Culture change will not occur overnight and striving for a true open and honest culture is an ongoing and perhaps never ending process. Normalising the reporting of concerns is only one building block of an open and honest culture; however, it can be an important issue in terms of patient safety.

This report and the recommendations contained within it are designed to create a framework where all staff understand the need to report appropriate concerns and feel totally comfortable raising those concerns.

RQIA wishes to thank the management and staff from the HSC organisations for their cooperation in taking forward this review, and the contributions from the other stakeholders for their input.

3.2 Summary of Recommendations

The recommendations identified during the review have been prioritised in relation to the timescales in which they should be implemented.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Implementation of the recommendations will improve the arrangements for raising concerns.

Number	Recommendation	Priority
1	The Department of Health should produce a model policy for raising concerns in HSC bodies in Northern Ireland. The process should take account of recent policy development elsewhere and seek expert advice where necessary.	Priority 1
2	All organisations should develop or continue to develop and support behaviours which promote and encourage staff to speak out, such as open forums, access to senior staff and board members where appropriate.	Priority 1
3	Each HSC organisation should appoint a non-executive board member to have responsibility for oversight of the culture of raising concerns within their organisation.	Priority 1
4	The Department of Health should establish a pilot confidential helpline to provide independent advice and support in relation to raising concerns, for HSC staff in Northern Ireland. The pilot should run for a period of at least one year, with an evaluation to be carried out prior to the pilot finishing.	Priority 1
5	Following development of a regional policy for raising concerns, awareness training in relation to raising concerns should be made available for all staff who might wish to raise a concern. This could take the form of a regional e-learning package.	Priority 2
6	All managers should receive bespoke training in the operation of their policy for raising concerns.	Priority 2
7	All organisations, particularly where appraisal rates are low, should work towards raising the uptake of staff appraisal.	Priority 1
8	All organisations should consider, where in their governance structures, responsibility for operating processes for raising concerns is best placed.	Priority 1

9	All organisations should routinely feedback at individual, team and organisational levels on concerns raised and how they were resolved.	Priority 1
10	All organisations should consider appointing an appropriate number of advisers/advocates to signpost and provide support to those wishing to raise a concern.	Priority 2
11	RQIA should include progress in relation to normalisation of raising concerns in the well-led domain of its regulatory programme.	Priority 1

Appendix 1 - Abbreviations

CQC	- Care Quality Commission
DHSSPS	- Department of Health, Social Services and Public Safety
DoH	- Department of Health
HR	- Human Resources
HSC	- Health and Social Care
INO	- Independent National (Whistleblowing) Officer
NAO	- National Audit Office
NHS	- National Health Service
NISCC	- Northern Ireland Social Care Council
PCaW	- Public Concern at Work
RQIA	- Regulation and Quality Improvement Authority
Southern Trust	- Southern Health and Social Care Trust

Appendix 2 – Staff Suggestions from Focus Groups

At the end of each focus group, participants were asked to propose some suggestions as to how their organisation could improve its whistleblowing arrangements. Those suggestions that were in effect a differently worded version of the same idea were grouped under a common heading. Furthermore, in processing the data captured, suggestions were grouped together in certain themes.

What follows is a summary of the findings.

Top Suggestions	
Training (no further specification)	33
Training for management	12
Mandatory training	11
Awareness, improvement through posters etc.	11
Assurances for confidentiality	9
Use different term	7
E-learning	6
Interactive awareness/workshop sessions	6
Independent whistleblowing contact in the trust	5
Talk about whistleblowing in team meetings	5
Flowchart/poster to show channels in raising concerns	4
Publication of positive outcome whistleblowing/reporting of number of cases	4
Feedback for whistleblower	4
Better support for whistleblower	4
Shortening investigations/clear-cut timeframes	4
Increase awareness of policy	4

Over 40% of all suggestions related to the need for training around whistleblowing.

While this was a huge finding, when considered alongside the findings of the main staff engagement report, it is perhaps not that surprising. It was clear that throughout the sector there was a lack of knowledge and understanding around the core principles of whistleblowing, right down to what the term even refers to. As a means of educating staff, training is the obvious solution to this problem.

Of those suggestions captured under the theme of training, there were some consistent more specific suggestions. The most common of the specific ideas (29%), was that there should be specific training for management around whistleblowing. This suggestion seemed largely borne out of the gross negative effect that management can have on the system if they don't handle instances appropriately. Many participants suggested that training should be mandatory, although many people felt that this would be unworkable, given the already large amount of training that needed to be undertaken.

One proposal that made up 15% of the training suggestions was to have compulsory e-learning. Several participants spoke of how this was a manageable and often quite effective way of conducting training.

The second most common grouping of suggestions related to ways in which management communicated to the staff body – i.e. management messaging.

Interestingly, similar to training detailed above, these sorts of suggestions also related to the way in which staff could be educated about whistleblowing. The most common suggestion (42%) in this category was a poster campaign designed to improve awareness around whistleblowing. Another popular idea as to how information on whistleblowing could be communicated was via a regular slot in team meetings. Many participants felt that this may normalise the process.

Another idea that was repeated on several occasions was to have flowcharts posted in wards detailing options for raising concerns, and in what order they should be attempted. Not all suggestions in this grouping related to informing staff of the arrangements for whistleblowing. It was also considered by some participants that management messaging could be used as a way to improve trust and confidence in the organisations whistleblowing arrangements. The most popular of these suggestions was for the organisation to publicise successful instances of whistleblowing where the problem was solved and the whistleblower unaffected. Many participants questioned the feasibility of this given various duties of confidentiality; however, the benefits of countering the media's overwhelming negative portrayal were seen to be a very worthwhile goal.

How concerns are handled (15%), points of contact for raising concerns (8%) and the term *whistleblowing* itself (6%), were all also popular topics.

Approaches to improving handling were mainly directed at improving things for the whistleblower. This made up 88% of the suggestions in this group, and this aim was evenly split between better protection of the whistleblower's identity (to avoid victimisation) and better support for the whistleblower. In the former category the prevalent view was for greater assurances around confidentiality, whereas in the latter sub-group, views were spread across better support, feedback for the whistleblower and shorter, or better time framed, investigations. Generally, this was slightly out of step with the views expressed in the sessions themselves, where protection of identity was often seen as the only way of making things better for whistleblowers. This might reflect the fact that participants had just not thought of other ways the organisation could improve measures, and that once this was put to them they saw the value in it.

Very often in the focus groups, there were discussions about what, if anything, to do with the term whistleblowing, given the negativity that surrounded it.

This unsurprisingly manifested itself in a significant proportion of participants putting forward suggestions related to this. The vast majority of suggestions were to change the name as means of escaping the stigma, although some participants suggested that a better route was to try and normalise it.

The majority of suggestions (71%) related to points of contact were for more internal options. The most common of these was for an independent whistleblowing contact within the organisation who sat outside of the line management chain.

Although a much smaller share of the total suggestions, many participants also put forward suggestions relating to the organisation's policy (5%) and the advice available to whistleblowers (3%).

Training		Points of contact		Messaging		Handling		The term		Advice		Policy		Other		
Mandatory training	11	Independent whistleblowing contact in the trust	5	Awareness improvement through posters etc	11	Joined up policy for incident reporting	1	Use different term	7	Independent source of advice	3	More accesible policy	3	Online system for raising concerns	2	
E-learning	6	Independent reporting contact outside of the trust	2	Flowchart/poster to show channels in raising concerns	4	Gateway teams' for handling whistleblowing concerns	1	Increase use of the term to familiarise/normalise it	3	Better awareness of advice available	1	Forced reading of policy	1	Cross-trust investigations	1	
Training for management	12	Senior management more visible / drop-in	2	Encourage staff to raise concerns	2	Improving audit of existing reporting arrangements	1	Better understanding	1	For managers	1	Simplified policy	1	"Have no fear of repurcussions for whistleblowing"	1	
Interactive awareness/worksh op sessions	6	Make reporting to senior management more straight forward	3	Talk about whistleblowing in team meetings	5	Assurances of confidentiality	10			On site advice	1	Increase awareness for policy	4	Responsibility for whistleblowing devolved to invidividual departments	1	
Training on policy	2	Independent external body that can mediate	1	Publicisation of positive outcome whistleblowing / reporting of number of cases	4	Feedback for whistleblower	4							Independent panel within trust to investigate whistleblowing concerns	2	
Training to complete at home	1	Making contacting RQIA easier	1			Better support for whistleblower	4							Code of practice for management in dealing with concerns	1	
Training on distinguishing from other reporting lines	1					Shortening investigations / clear-cut time frames	4							Discipline managers who breach confidence	2	
Training for investigators	1					Guaranteed anonymous way of raising concerns	2							Improve confidence in reporting	1	
Induction training	1															
Training (no further specification)	33															
	74		14		26		27		11		6		9		11	178
	41.57%		7.87%		14.61%		15.17%		6.18%		3.37%		5.06%		6.18%	100.00%

Appendix 3 – Case Studies

During each day of focus groups, an opportunity was provided for those with first-hand involvement of whistleblowing to talk with PCaW directly, so that their experiences could be included within the report.

There were several stories which PCaW felt, given the sensitivity of the case, would not be appropriate to include. This was due to a risk that the individual would be identified by the nature of the facts and their situation could potentially be made worse.

Of those stories that PCaW felt could be anonymised, a selection of these case studies have been detailed below. In addition to telling the individual's unique story, while still retaining the spirit of the experience, the case studies demonstrate some of the more general challenges faced in getting whistleblowing arrangements right.

Potential Consequences

Several participants spoke about the potentially damaging, and unnecessary effects that whistleblowing can have on their own personal circumstances. One of these stories highlighted the stark contrast between the positive change that the person was trying to make and the eventual personal cost that they had to endure.

An individual advised of raising serious concerns about another colleague, who apparently in a fit of temper, had shouted, man-handled and took away the belongings of a patient who had severe pre-existing anxiety issues. The whistleblower took the concerns to their manager, but fearing a reaction from the staff member implicated, had requested that their identity be kept confidential.

Confidentiality was not maintained and the disclosure eventually made its way back to the guilty party, who apparently then proceeded to manipulate the team against the individual who raised the concern. The individual advised that trusted colleagues turned against them, resulting in the individual suffering stress and distress, and subsequently having to take time off work. The individual described in vivid terms how their health, both physical and mental, deteriorated as they tried to cope with the circumstances.

Although the individual was back in employment and generally recovered, they described the intense anger they had towards the way that their manager had handled the incident. The lack of confidentiality resulted in challenging times for the whistleblower, and a presumed knock-on effect of fear, for anyone who might think of raising a concern in the future.

Anonymous Concerns

During a one-to-one session, a participant described their experiences of the effects that anonymous concerns can have on staff, and the delivery of service. The individual worked in a clinical environment which had, over the course of a short period of time, been the subject of several anonymous letters written to senior management. The participant explained that the consequent long investigation times and lack of knowledge surrounding the issues permeated a culture of fear, distrust and uncertainty throughout the team. They advised that there was a clear loss of morale and suggested that the service provided was less effective, as staff no longer trusted their instincts and were constantly checking every decision with management.

Of the concerns where investigations had concluded, the participant advised that no action had been taken. The participant acknowledged the need for workers to be able to raise their concerns in any way possible, but stated that these incidents had come at a high cost for their team. They advised that the team was also no clearer as to the specific circumstances surrounding the concerns, and rumours had spread that the concerns raised were vexatious. The participant questioned what action their team or the trust could do to protect themselves in this instance.

Challenges for Trade Unions

On many different occasions there were discussions about the role that the trade unions played with respect to whistleblowing. Many participants advised that if they were unsure how to raise concerns, or needed support in doing so, they would approach their trade union.

A core function of the Union is their duty towards their members. This however, became a particular challenge in cases where they had to support staff on both sides of a concern.

Handling of Concerns by Management

During the course of the staff engagement exercise, PCaW met with a clinician in one of the trusts, who described how multiple members of the staff had separately raised concerns about a particular site. The individual explained how staff not only had identified problems, but also suggested practical and attainable solutions.

The clinician advised that staff felt they were unable to escalate their concerns beyond a particular level of management, the positions became entrenched, relationships broke down, and ultimately the concerns remained. The situation has since improved; however, according to the individual, many of those involved in raising the concerns left the organisation, as a result of how this was handled.

Lack of Feedback – a Missed Opportunity for a more Positive Outcome

For many whistleblowers, the potential victimisation from colleagues can be a major concern. This was a particular concern for one individual who spoke with PCaW.

An individual advised of being concerned about the level of professionalism by some managers within the team, and the knock-on effect that this was having on the service users.

They advised of following the whistleblowing policy, and stated that initially it worked well for them, as it provided an avenue for the concerns to be raised outside of line management. However, once the concerns had been detailed to senior management, the individual stated that they were considered no longer involved in the process. They stated that HR sometimes contacted them, but not with any updates in relation to the concerns.

Due to the lack of feedback, the individual stated that they could only speculate on what was happening. They did not know, and were concerned about, whether others knew that they raised the concern. The individual advised of becoming somewhat paranoid about any potential consequences. As a result, they advised of becoming stressed, which was starting to impact on their health. They found it hard to cope and subsequently had to take time off work. After an extended period of absence, they advised that they are only now starting to get back to normal.

The participant described how whistleblowing, even when they are not directly involved, can be an extremely stressful experience, and especially when there is no support during the process.

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death [redacted]	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review Within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the [redacted] Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
Review of General Practitioner Out-of-Hours Services	September 2010

Review	Published
RQIA Independent Review of the [redacted] Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
RQIA's Overview Inspection Report on Young People Placed in Leaving Care Projects and Health and Social Care Trusts' 16 Plus Transition Teams	August 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013

Review	Published
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015

Review	Published
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory Services in Northern Ireland	February 2016
Review of the Northern Ireland Ambulance Service	March 2016
Review of HSC Trusts' Readiness to Comply with Allied Health Professions Professional Assurance Framework	June 2016
RQIA Publishes Overview of Quality Improvement Systems and Processes in Health and Social Care	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care