Speaking Up Safely

Final Internal Audit Report

January 2025

Swansea Bay University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
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Contents

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To review the implementation of the Speaking Up Safely framework and assess its impact in promoting a culture that enables staff to raise concerns.

Overview

We have issued limited assurance on this area.

The matters requiring management attention include:

- Review of the actions included in the plan submitted to the Welsh Government to ensure they remain appropriate, as well as consider the recommendations raised in the Guardian Service annual report.
- Enhancement of the understanding of line managers of the requirements of the Speaking Up Safely framework.
- The need to improve the capture and recording of concerns raised via the various internal mechanism.
- Strengthening of the governance reporting and structure within the Service Groups, to ensure compliance with national policies and the Speaking Up Safely framework

Report opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Raising Concerns Process	Limited
2	Methods for Speaking Up Safely	Reasonable
3	Management of Concerns Raised	Reasonable
4	Monitoring, review and analysis of concerns raised	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Delivery of the Speaking Up Safely Action Plan	1	Operation	High
2	Embed framework requirements within training resources	1,3	Operation	Medium
3	Monitoring and reporting of internal concerns	2,4	Operation & Design	High

1. Introduction

1.1 The NHS Wales Speaking Up Safely Framework (WHC/2023/036) 'The Framework' states that '*this is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised'*.

1.2 Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce; as well as helping to improve the population's experience of healthcare. In addition to the Framework, since 2019, the Guardian Service (an externally appointed service) has been available at the health board 24/7, 365 days a year for staff, students and volunteers to raise work related concerns independently and anonymously. This service is an integral part of implementing the health board's culture change programme and supports the 'One Bay Way' and People Strategy.

1.3 Following the Lucy Letby verdict, in August 2023, the Welsh Government set out the expectation for NHS organisations to undertake a self-assessment against the organisational requirements detailed in section 6 of the Framework and develop an action plan to address any gaps between current practice and the expectations of the Framework. The health board completed and submitted its action plan in October 2023.

1.4 The potential risks considered at the outset of the review were as follows:

- Poor practice not being challenged due to staff not feeling confident to raise a concern.
- Staff are unaware of the Speaking Up Safely framework and are therefore unclear how to report a concern.
- Concerns are not documented, investigated or acted upon appropriately.
- The Board may not be aware of serious concerns relating to the performance of the organisation.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			
	High	Medium	Low	Total
Control Design	1	-	-	1
Operating Effectiveness	4	1	-	5
Total	5	1	-	6

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Objective 1: The process for staff to raise concerns is clearly documented and subject to regular review.

2.3 National guidance documents which outline requirements for staff to raise concerns include:

- Speaking Up Safely: A Framework for the NHS in Wales (2023); and
- Putting Things Right Guidance (updated 2023).

2.4 The Health and Social Care (Quality and Engagement) (Wales) Act 2020; and the Public Interest Disclosure Act 1998 are also applicable to the process for raising concerns. Codes of Practice provided by the NMC (Nursing Midwifery Council), HCPC (Health and Care Professions Council) and GMC (General Medical Council) are also relevant.

2.5 The Duty of Candour (the requirement to be honest and transparent with patients and families who use NHS services) closely aligns to Putting Things Right. We acknowledge that Speaking Up Safely is wider than the duty of candour, but there may be situations where it is necessary to exercise both to effectively provide patient care in the future.

2.6 The health board published its 5-year Quality Strategy in March 2023. Feedback received following the 'Our Big Conversation' staff engagement programme, led to the development of 10-year 'Organisational Vision' published in September 2023 to become a 'High Quality Organisation', with an open and honest culture where staff have a voice and their feedback is heard and responded to.

2.7 There are a number of policies and procedures in place which outline the process for staff to raise concerns, including:

- Procedure for NHS Staff to Raise Concerns – to be read in conjunction with the Speaking Up Safely Framework (adopted following approval by the Welsh Partnership Forum Business Committee);
- Respect and Resolution Policy (adopted following approval by the Welsh Partnership Forum Business Committee);
- Disciplinary Policy and Procedure (adopted following approval by the Welsh Partnership Forum Business Committee);
- Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in positions of Trust (Professional abuse / concerns policy); and
- Concerns Management Policy.

2.8 We noted that a number of the above policies had surpassed their review dates but acknowledge that these are national documents and were informed that it has been agreed at the All Wales Partnership Forum that national policies will no longer require a review date.

2.9 The staff handbook, issued to all employees when joining the health board, provides a means by which to signpost the existing Raising Concerns arrangements at the health board. We note that it is currently under review and will need to be reflective of the local mechanisms/guidance that have been implemented as a result of the requirements of the Speaking Up Safely Framework.

2.10 The process to raise concerns is signposted on the health board's Raising Concerns SharePoint intranet page. However, the need to develop and improve this site was included within the action plan submitted to Welsh Government (see para 1.3, para 2.12, and Appendix B). We are advised that the review is to be undertaken in partnership with a stakeholder group, including representatives from Corporate Governance, Corporate Nursing, Department of Insight, Communications and Engagement (DICE), Trade Union Partners, Workforce, Wellbeing, Safeguarding and Chaplaincy.

2.11 Whilst efforts have been made to try and establish this group, in line with the health board's action plan, at the date of reporting this has not been achieved. See **Matter Arising 1** and Appendix B.

2.12 Progress against the action plan has been slower than anticipated due to restructures and gaps in resource, within the operational HR team, impacting delivery across priorities. Of the eight actions included in the plan, only one has been addressed to date and target timescales for the remaining seven have lapsed. Whilst the action plan is sponsored by the interim Director of Workforce and Organisational Development (OD), successful delivery requires commitment from across the health board. The plan's delivery status was reported as 'amber' at the August 2024 Workforce, OD and Digital Committee, but still achievable within the year.

2.13 Management advised that current capacity is likely to impact the ability to meet the requirements of the Framework and therefore a risk is being developed for inclusion on the health board risk register. See **Matter Arising 1**.

Conclusion:

2.14 The process for staff to raise concerns is documented within national guidance as well as within a number of All Wales policies and procedures adopted by the health board. Implementation of the action plan submitted to Welsh Government to address the requirements of the Framework is off track, with only one action addressed to date. Accordingly, we assign this objective **limited** assurance.

Objective 2: Staff are aware of the process for raising a concern and can do so with confidence that they will be fully supported and not suffer detriment as a result.

2.15 There are several means through which health board staff can speak up, see Appendix C. In addition to their line manager, staff are also able to raise concerns through their trade union representatives, the Workforce Team and the Occupational Health and Staff Wellbeing Service whether it be at the point a concern is raised informally or formally. There are a number of Wellbeing

Champions across the health board that staff can access support, as well as diverse Staff Networks, the Chaplaincy and Spiritual Care Service.

2.16 Concerns can also be raised via the Datix incident reporting system, the Safeguarding Team, Health and Safety, and the independent Guardian Service (see para 1.2). These resources are promoted under the useful links section of the Culture, OD and Staff Experience pages of the internet and the intranet, noting work is required to develop and improve this site (see para 2.10 and **Matter Arising 1**).

2.17 The Thinking of Leaving Pilot (in the final stages of decommission at the date of fieldwork) was another method by which concerns could be raised. However, the anonymity of the data collected meant it was difficult to determine whether the initiative had had a positive impact, therefore the decision was taken to resource activity which could add more value.

2.18 The Guardian Service, an independent listening and empowering service, that was introduced at the health board in May 2019, has recently been re-tendered at a cost of circa £100k for up to 100 contacts per annum (with a charge for each subsequent contact of £320). As per para 2.16, the service is promoted organisation-wide via notifications on ESR (Electronic Staff Record), Datix and through the Wellbeing Champions. The Guardian Service also has its own section on both the intranet page and the health board's website. Additionally, there are posters promoting the service displayed across health board sites.

2.19 We are advised that visits to health board sites are also arranged to speak to staff and raise awareness of the Guardian Service; and that they can be asked to undertake targeted activity when appropriate for example, a recent 'lunch and learn' session was delivered to the Patient Feedback department (see also para 2.47). A roadshow to promote the service is also planned across all Leadership Forums, in the coming months, recognising health board structure changes since the Guardian Service was introduced – refer to ***objective 4*** for further details on how the service engages across the organisation.

2.20 In addition, the Culture, OD & Staff Experience Team support and promote the resources available on a regular basis through Management & Leadership touch point sessions, bespoke team development and personal development workshops and awareness raising events, for example October's Speak Up Month, November's Anti-bullying Week, Café Conversations at NPT and Singleton; and Cultural Conversations which have recently commenced in MH&LD.

2.21 Data confirms that the organisation does 'listen', however there is a gap in respect of taking action and communicating what has been done as a result of staff speaking up (See **Matter Arising 3** and ***objective 4*** for further details on reporting / lessons learned). This is replicated in the results of the NHS Wales Staff Survey (2023), for which a 18.8% response rate (2,625 individuals) was recorded for the health board:

- 74% of respondents felt they were able to speak up in their team if they notice poor / incorrect practice.

- 40% of respondents, however, felt that if they spoke up about something that concerned them the organisation would address their concern.

2.22 We were advised that this data was reported to Management Board, WOD Development Group and WOD Committee. It was also shared with Service Groups and Directorates to identify two or three key areas of improvement / focus as a result. Examples provided demonstrated particular focus on sickness absence (as highlighted in our Sickness Absence Management report: issued October 2023; reasonable assurance) with a hot spot audit undertaken at Morriston, recognising that such absence may be associated with work-related issues. In addition, discussions will be held with the Workforce Business Partners to ensure these areas of focus link back to local People Experience Plans and feed into the delivery of the overall People Strategy.

2.23 Operationally, 'Trainee Forums' are held on a monthly basis, led by each specialty area to support trainees in their roles. These typically involve service group managers, representatives from medical human resources, postgraduates and faculty leads. Whilst not specific to Speaking Up Safely, they do provide a safe space to raise concerns / ask advice. In addition, there are booklets and also posters providing access to a QR code to raise any medical training concerns.

2.24 Internal procedures for raising concerns make it quite clear that staff have the right to raise concerns without the fear of victimisation; and such is reiterated through the dedicated speak up month of October and wider examples of engagement – see para 2.20. Monthly reports produced by the Guardian Service monitor the reasons staff use the service. The latest cumulative activity report for the end of the 2023/24 financial year highlighted that 38.3% of staff contacted the service as they believed they will not be listened to within the health board; 37.5% have raised concerns previously but have not been listened to; 14.8% sought impartial support; and 4.7% were due to fear of reprisal or for other reasons respectively. As staff that use the service have the option to keep the concern confidential or to escalate anonymously (see table 1 under ***objective 4***), this also enables detriment to staff to be avoided.

Conclusion:

2.25 There are a number of internal mechanisms through which staff can speak up, including access to the independent Guardian Service, and the Culture, OD & Staff Experience Team support and promote the resources available on a regular basis. However, is it recognised that there is a need to develop and improve the health board's raising concerns intranet page and to better demonstrate action taken as a result of staff speaking up. Noting this, we have assessed **reasonable** assurance for this objective.

Objective 3: Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately.

2.26 The Interim Director of Workforce and OD is the Executive Lead for Speaking Up Safely; and the Chair and an Independent Member (who currently chairs the

Workforce, OD & Digital Committee) are designated Speaking Up Safely Champions. The Head of Culture, OD and Staff Experience is the Operational Lead.

2.27 It is the responsibility of line managers and Service Groups to manage and investigate concerns raised, and there are a number of resources in place to provide guidance. Support can also be sought from the Head of Culture, OD and Staff Experience and HR Business Partners.

2.28 Raising Concerns is a core part of the corporate induction programme, and is also embedded into the Management and 'Leadership Development Programmes. Training and support is also received from Improvement Cymru as part of the Safety Care Collaborative and this includes '*Coaching for Improvement*' and '*Leading for Patient Safety*' training.

2.29 In addition, methods for managers and staff to speak up and the Respect and Resolution Policy are signposted through the Civility Saves Lives training which is being rolled out. Duty of Candour Q&A drop-in sessions, on-line training videos and awareness raising are also available to all staff. Management review workshops are also held and sessions via the Managers Pathway; further, the Managing Attendance at Work training includes the importance of compassionate leadership, early intervention and prevention. We note that whilst these aren't mandatory courses uptake is recorded, monitored and evaluated.

2.30 The health board has already recognised (included within the action plan submitted to Welsh Government – see Appendix B) that more work is needed to embed the requirements of the national Speaking Up Safely Framework within the training offerings. We understand that the Learning & Education arm of the Leadership and OD Directorate is actively planning the introduction of 'Brilliant Basics' bitesize learning opportunities alongside the Behaviour-based Leadership Development offerings delivered by the Culture OD and Staff Experience Directorate. See **Matter Arising 2**. This would allow staff access to training resources in real time as the need arises.

2.31 Recently some work was also undertaken with the GMC and NMC within specialty areas, with the aim of cultivating a supportive working environment therefore promoting an environment where someone could speak up safely if the need arose.

2.32 The Guardian Service annual report also raises concerns around the lack of adherence to the requirements set out in policies, including timescales, appropriateness of investigations and actions undertaken such as suspension, and the lack of ongoing engagement and wellbeing support offered to staff (see ***objective 4***). The health board is also working with colleagues from Health Education Improvement Wales, NWSSP Legal and Risk as well as Aneurin Bevan University Health Board to roll out '*Employee Investigations: Looking after your people and the process*' training. This is aimed at HR teams, line managers and trade union reps with the purpose of improving employee investigations and removing avoidable employee harm.

2.33 We also note that the health board launched a Best Practice review in 2023 which is a collaborative project with Trade Unions to address all aspects of employee relations and managing staff. The health board have recently commenced by

looking at disciplinary, grievance and sickness absence management, for which the changes to process will take time to mature; and will continue in all areas as concerns arise.

Conclusion:

2.34 There are defined corporate leads for Speaking Up Safely at the health board. Training is available to support managers with responsibility to manage concerns raised. The Guardian Service annual report raises concerns around the lack of adherence by line managers to the requirements set out in policies, but there is recognition within the health board that more work is needed to manage such and further embed the requirements of the national Speaking Up Safely Framework and such is being addressed through the Best Practice review being undertaken. Therefore, we have provided **reasonable** assurance for this objective.

Objective 4: Concerns raised by staff are monitored, reviewed and analysed to identify recurring themes or trends, with issues escalated as appropriate.

2.35 There are several mechanisms in place within the health board to capture and record concerns raised across the various methods available to staff to speak up. These include formal arrangements, such as the Datix system (e.g. staff-to-staff incidents), the workforce central mailbox, the HR database (recording both formal and informal concerns), professional safeguarding concern referrals, the Guardian Service (being the main route staff use to raise concerns anonymously); and informal routes with Trade Unions, HR Business Partners and the HR team, on the ground, being the first point of contacts for employees.

2.36 There is recognition also within national guidance that most disagreements can be resolved quickly and informally through discussion with colleagues or a line manager. Due to their nature a formal audit trail won't typically be maintained to capture themes and trends as a result.

2.37 The need to improve the capture and recording of concerns raised is recognised within the action plan submitted to Welsh Government (Appendix B). See **Matter Arising 3**. We understand that discussions are ongoing between the Interim Head of Workforce Effectiveness & Analytics and the Workforce Data Analyst to determine how such a report could be developed, alongside the development of data dashboards.

2.38 It is the responsibility of the Service Groups to ensure concerns raised are appropriately investigated and managed by line managers. High level reporting of the number of incidents was evident, however these provide limited detail on the caseloads resulting in a lack of assurance to demonstrate that the requirements of national policies and the Speaking Up Safely framework are being met. The need to improve governance reporting and structure within the Service Groups is also recognised within the action plan submitted to Welsh Government (see **Matter Arising 1**). Service Groups have also been asked to undertake their own self-assessments against section 6 of the national Speaking Up Safely Framework. We were also informed that an 'Open Incident Reduction Plan' has been proposed to reduce the number of incidents open on Datix. See **Matter Arising 3**.

2.39 In addition to the internal mechanisms, the health board has invested an independent and confidential staff liaison service provider calls the Guardian Service. It is recognised within the health board as an integral part of implementing its culture change programme and supports the 'One Bay Way' and delivery of the People Strategy. It has been reported that the number of staff raising concerns and speaking up has significantly increased since the service was introduced, and that many staff members have emphasised that a deciding factor in their decision to speak up was that the Guardians are external to the health board.

2.40 The most recent annual report from the Guardian Service stated that a key feature from many of the concerns raised with them is that the timescales set out in policies are not being adhered to, citing a lack of awareness amongst line managers and a failure to seek guidance before acting.

2.41 The report also raises concerns around the way suspension from work has been implemented, with staff impacted not clear on the reasons why; and a lack of engagement from line managers has resulted in the need for the Guardian Service to step in and provide a high level of emotional support. The lack of contact can cause increased stress and usually an extended absence from work.. As per para 2.32, we note that the health board has recently implemented a new approach to suspensions, as a result of the Best Practice review undertaken, which includes requirement of completion of a comprehensive checklist to ensure the decision is fully assessed and risk assessed appropriately, and support from the Assistant Director of WOD is required before sign off.

2.42 Monthly reports from the Guardian Service provide the number of new contacts and closed/resolved contacts per month and year to date. In line with maintaining anonymity, reports are broken down by staff group, service group / directorate and themes of the concerns raised. The two most common themes are 'management concern' and 'system and process'.

2.43 The Guardian Service meet with the with the Chair and Independent Member speak up champions every 8 weeks. Monthly monitoring and reporting meetings are also held with the Director of Workforce & OD. Both forums assist with assurance and support and guide the organisations approach regarding areas for concern and where the health board needs to prioritise support (whilst still maintaining anonymity). The Head of Culture, OD & Staff Experience reports on Speaking Up Safely to Management Board. In addition, monthly activity reports are shared with HR Business Partners to assist in triangulation with other Workforce intelligence across the Service Groups.

2.44 Speaking up Safely is reported within the Board governance structure, with bi-annual Guardian reports and plans presented the Workforce, OD and Digital Committee and annual reports presented at the Audit Committee. The Health Board's Quality and Safety Committee also has sight of relevant incidents and quality and safety concerns. Staff Stories have also been presented to the Board, although the need a more formalised resource for the provision of these in order to triangulate experience with patient stories is highlighted within the action plan submitted to Welsh Government.

2.45 We note that the intelligence the health board can gain to better understand the specific nature of the concerns raised with the Guardian service is limited due to the number of concerns being kept anonymous and the small number where permission is given to escalate (although the more recent data in Table 1 suggests an increase in psychological safety, with staff willing to escalate with their name):

Table 1: Extract from the Guardian Service monthly report (for the period April to August 2024)

Confidentiality	Number of concerns 2023/24		Number of concerns up to August 2024	
Keep it confidential within Guardian Service remit	108	84.38%	32	66.67%
Permission to escalate with name	9	7.03%	8	16.67%
Permission to escalate without name	3	2.34%	4	8.33%
Permission to escalate anonymously	8	6.25%	4	8.33%
Total	**128**	**100%**	**48**	**100%**

2.46 Noting that circa 38% of concerns relate to those raised previously within the health board but have not been listened to (see para 2.24), it is therefore possible that the concern could be logged onto Datix as well, but noting the lack of data triangulation there are no means to confirm. Data triangulation with other workforce intelligence i.e. staff survey, staff to staff incidents from Datix, ER cases would help provide a holistic picture.

2.47 Having said that, during the year there have been specific engagements in the following areas of concern: Morriston Acute Medical Unit and Emergency Department Morriston, Maternity Services at Singleton and Neath Port Talbot, Mental Health & Learning Disabilities at Hafod Y Wennel & Bryn Afon; and Singleton Theatres.

2.48 Other indicators supporting Speaking Up Safely such as grievances and respect & resolution cases, bullying and harassment and other employment related cases are also reviewed at the Workforce, OD and Digital (WOD) Committee. However, as with similar to the reporting at Service Group level (see para 2.38), the report content is limited to providing high level case number figures and brief supporting narrative and it is not clear how this information triangulates with the other mechanisms to capture and report concerns.

2.49 We also note that there has been limited monitoring of the delivery and implementation of the Speaking Up Safely Action Plan post submission to Welsh Government (see **Matter Arising 1**). A recent update to both the WOD and Audit Committees highlighted that the dates included within the action plan had lapsed due to restructure within Culture, OD and Staff Experience, and gaps in resource to deliver across priorities. However, the health board is committed to support this work at pace going forward with its key stakeholders.

Conclusion:

2.50 The independent Guardian service is recognised within the health board as an integral service, serving as an important additional avenue for staff to raise concerns anonymously that may otherwise go unheard. Whilst the service is

reported within the Board governance structure, due to its confidential nature and the lack of permission given by those raising concerns to escalate, there is the risk of limitations to the health board's ability to address and resolve issues raised by its staff through this route. In addition, there are several established mechanisms in place internally within the health board to raise concerns, however the need to improve the capture and recording of these in a more integrated manner is recognised, along with the need to strengthen governance reporting and structure within the Service Groups to ensure compliance with national policies and the Speaking Up Safely framework. Accordingly, we assign this objective **limited** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Delivery of the Action Plan (Operation)	Impact
Following the Lucy Letby verdict, in August 2023, the Welsh Government set out the expectation for NHS organisations to undertake a self-assessment against the organisational requirements detailed in section 6 of the Framework and develop an action plan to address any gaps between current practice and the expectations of the Framework. The health board completed and submitted its action plan in October 2023. Progress against the action plan has been slower than anticipated due to restructures and gaps in resource impacting delivery across priorities. Of the eight actions included in the plan, only one has been addressed to date and target timescales for the remaining seven have lapsed. Whilst the action plan is sponsored by the interim Director of Workforce and Organisational Development (OD), successful delivery requires commitment from across the health board. The plan's delivery status was reported as 'amber' at the August 2024 Workforce, OD and Digital Committee, but still achievable within the year. Management advised that current capacity is likely to impact the ability to meet the requirements of the Framework and therefore a risk is being developed for inclusion on the health board risk register.	Potential risk of: • Protracted timescales for meeting the action plan; • The objectives of the Speaking Up Safely: A Framework for the NHS in Wales (2023) are not achieved.

Recommendation		Priority
1.1	The action plan should be revisited to ensure the actions included in October 2023 remain appropriate, address the recommendations that have since been raised in the Guardian Service annual report, have appropriate assigned responsible officers and reasonable timescales for completion.	**High**
1.2	Regular reporting, to an appropriate forum, should be undertaken regarding the progress of implementation of the action plan.	
1.3	The development of a risk should be finalised to ensure the health board's risk register is appropriately reflective of the capacity to meet the requirements of the framework.	

Agreed Management Action		Target Date	Responsible Officer
1.1	An initial exercise has been undertaken in December 2024, post completion of the audit, to update the action plan to reflect the status of each action. The action plan will be revisited / refreshed to ensure the actions remain appropriate, including consideration to incorporate the recommendations raised by the Guardian Service. Once complete, the revised action plan will be approved by the Speaking Up Safely Working / Stakeholder Group where its implementation will be monitored (see 1.2)	31 March 2025	Director of Workforce & OD
1.2	Outputs of the Speaking Up Safely Working / Stakeholder Group are to be monitored and reported quarterly via the Workforce & OD Delivery Group and 6-monthly via the Health Board Workforce & OD Committee.	Delivery Group: March, June & December 2025 Committee: September 2025 & March 2026	Director of Workforce & OD
1.3	Head of Culture, OD & Staff Experience to work in partnership with stakeholders to develop a risk for the risk register. This risk will be monitored and reported on a 6-monthly basis via the Workforce & OD Committee. *Note: Risk will take in account progress already made as well as delivery against Section 6 of the National Framework as a whole, but also resource and capacity.*	31 March 2025 (with monitoring ongoing in line with committee dates)	Head of Culture, OD & Staff Experience Director of Workforce & OD

Matter Arising 2: Embed Speaking Up Safely Framework requirements within training (Operation)	Impact
It is the responsibility of line managers and Service Groups to manage and investigate concerns raised, and there are a number of resources, including training pathways, in place to provide guidance. Support can also be sought from the Head of Culture, OD and Staff Experience and HR Business Partners. As has been recognised in the action plan submitted to Welsh Government (see Appendix B; and Matter Arising 1), more work is required to embed the requirements of the national Speaking Up Safely Framework within the training offerings. Management has advised that work is being undertaken to plan the introduction of bitesize learning opportunities, alongside the behaviour-based leadership development offerings currently delivered. Such would allow staff access to training resources in real time as the need arises. The Guardian Service annual report also raises concerns around the lack of adherence to the requirements set out in policies, including timescales, appropriateness of investigations and actions undertaken such as suspension, and the lack of ongoing engagement and wellbeing support offered to staff. The health board is also working with colleagues from Health Education Improvement Wales, NWSSP Legal and Risk as well as Aneurin Bevan University Health Board to roll out '*Employee Investigations: Looking after your people and the process*' training. This is aimed at HR teams, line managers and trade union reps with the purpose of improving employee investigations and removing avoidable employee harm. Whilst we note the work being undertaken as part of the Best Practice review, the changes applied are recent and the sustainability of such will only be confirmed once they have taken time to mature.	Potential risk of: • Failure to support members of staff when they speak up; • Failure to follow due process leading to staff leaving the organisation or moving department or being absent as a result of sickness.

Recommendation		Priority
2.1	The review of the training modules, including the development of the 'Brilliant Basics' bitesize learning opportunities, should be finalised and made accessible to the relevant staff members.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	Speaking Up Safely Awareness Raising is already built into Civility Saves Lives Workshops, our Management & Leadership Development Programmes, annual Speak Up Month, Monthly Team Brief, Corporate Induction, Wellbeing days, Doctors Grant Round, Induction for Internationally Educated Nurses and Junior Doctors Induction, including sign posting to the HEIW toolkits for learners and students (medical and non-medical). However, this action will continue to be delivered and evaluated collectively via the Speaking Up Safely Working Group as an objective of that group: • To maintain communications, training and/or resources for employees and managers on how to speak up safely and importantly take appropriate action/feedback as a result of someone speaking up/raising concerns. Brilliant Basics is due to launch in its initial phase, as a pilot mid-January. This content will be prioritised in the months following in from the initial launch, linked to the revised Raising Concerns SharePoint Pages.	30 June 2025	Director of Workforce & OD

Matter Arising 3: Recording, monitoring and reporting of internal concerns (Design & Operation)	Impact
Monthly reports from the Guardian Service provide the number of new contacts and closed/resolved contacts per month and year to date. In line with maintaining anonymity, reports are broken down by staff group, service group / directorate and themes of the concerns raised. The two most common themes are 'management concern' and 'system and process'. The most recent annual report from the Guardian Service stated that a key feature from many of the concerns raised with them is that the timescales set out in policies are not being adhered to, citing a lack of awareness amongst line managers and a failure to seek guidance before acting. The report also raises concerns around the way suspension from work has been implemented, with staff impacted not clear on the reasons why; and a lack of engagement from line managers has resulted in the need for the Guardian Service to step in and provide a high level of emotional support. There are several mechanisms in place within the health board to capture and record concerns raised across the various methods available to staff to speak up. The need to improve the capture and recording of concerns raised is recognised within the action plan submitted to Welsh Government (see Matter Arising 1 and Appendix B). We understand that discussions are ongoing between the Interim Head of Workforce Effectiveness & Analytics and the Workforce Data Analyst to determine how such a report could be developed, alongside the development of data dashboards. It is the responsibility of the Service Groups to ensure concerns raised are appropriately investigated and managed by line managers. High level reporting of the number of incidents was evident, however these provide limited detail on the caseloads resulting in a lack of assurance to demonstrate that requirements of national policies and the Speaking Up Safely framework are being met. The need to improve governance reporting and structure within the Service Groups is also recognised within the action plan submitted to Welsh Government. Service Groups have also been asked to undertake their own self-assessments against section 6 of the national Speaking Up Safely Framework. We were also informed that an 'Open Incident Reduction Plan' has been proposed to reduce the number of incidents open on Datix.	Potential risk of: • Limited assurances in respect of all concerns raised from all sources; • Limited opportunities to learn from lessons.

Recommendation			Priority
3.1	The development of an integrated report including data from all sources that receive concerns should be finalised to empower the health board to have complete oversight of all concerns, themes and trends.		High
3.2	Service Groups should amalgamate the detail of concerns raised (themes, trends, actions taken, lessons learned) and report to an appropriate Board-level committee to have an organisation-wide understanding of incidents arising. The reporting should also provide assurance that policy requirements, including timescales etc, are being adhered to.		
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Work has commenced with the Guardian Service Alliance and Hywel Dda to learn from the experience, systems and processes that other Health Boards and Trusts have in place to integrate and triangulate all sources that receive concerns to empower the health board to have complete oversight of all concerns, themes and trends. This will also form part of the collective objectives of the Speaking Up Safely Working Group.	31 March 2026	Director of Workforce & OD in partnership with the Director of Corporate Governance and Executive Director of Nursing
3.2	Service Groups to amalgamate the detail of concerns raised (themes, trends, actions taken, lessons learned) and report to Workforce & OD Delivery Group quarterly and Workforce & OD Committee as part of the overarching Speaking Up Safely Monitoring and Reporting, providing assurance that the national Framework Requirements are being adhered to.	Delivery Group: March, June & October 2025 Committee: September 2025	Service Group Directors

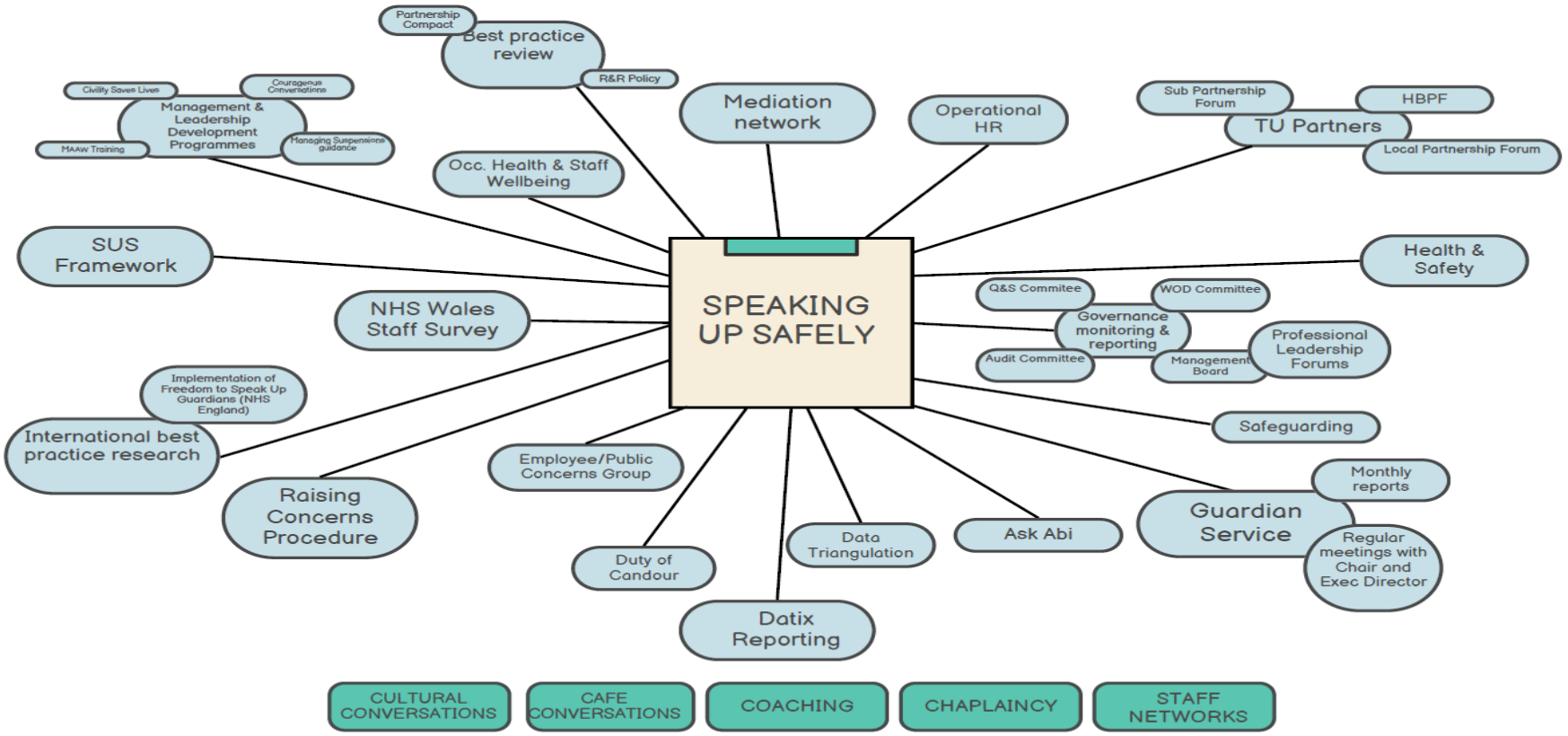
Appendix B: Swansea Bay UHB Action Plan

The following table outlines the key actions identified as a result of completing the Self-Assessment against Section 6 of Framework for Speaking Up Safely in NHS Wales (submitted October 2023 and timeframe status as at date of audit fieldwork)

	Action	Responsible Lead	Timeframe
1	Patient and Stakeholder Experience Group (PSEG) to continue to work to strengthen approaches to triangulating patient and staff experience.	Executive Director of Nursing & Director of Workforce & OD	Quarter 3, 2023 on-going
2	Continuation of unannounced quality assurance audit programme to measure the quality of our care through a range of metrics, including patient and staff feedback.	Executive Director of Nursing	Quarter 3, 2023 on-going
3	Use the outcome of the Audit Wales review, looking at governance arrangements in the service groups to inform improvements in our governance reporting and structure. At the same time, ask Service Groups to Self-Assess against section 6 of the national Speaking Up Safely Framework.	Director of Corporate Governance, Director of Workforce & OD & Service Group Directors	Quarter 1, 2024
4	Identified a more formalised resource for the provision of Staff Stories in order to triangulate experience with patient stories.	Director of DICE	Quarter 1, 2024
5	Embed the national Speak Up Framework and branding into the Health Board's Management & Leadership Programmes, bespoke team development and personal development workshops and events, values-led and Nurse Induction programme and future national events such as October's Speak Up & Safeguarding Month and November's Anti-bullying Week.	Director of Workforce & OD & Executive Director of Nursing	Quarter 3, 2024 on-going The National Speaking Up Safely Framework was launched and promoted as part of National Speak Up Month 2023. There is further work to be done to fully embed the framework and branding across

	Action	Responsible Lead	Timeframe
			our programmes and materials. 2024 Speak Up Month planning is underway.
6	Develop and improve the Raising Concerns' page of the Staff Intranet and include the national branding and Framework for Speaking Up Safely in NHS Wales.	Director of Workforce & OD, Direct of DICE, Director of Corporate Governance & Executive Director of Nursing	Quarter 3, 2024
7	Establish a working group to improve the capture and recording of concerns raised from across the various methods / options staff have to raise concerns (outside of the Guardian Service).	Director of Workforce & OD, Direct of DICE, Director of Corporate Governance & Executive Director of Nursing	Quarter 2, 2024
8	Complete the re-tender of the Guardian Service.	Director of Workforce & OD	Completed 1st December 2023

Appendix C: Speaking Up Safely – options available



Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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