# Whistleblowing (How to Raise a Concern) Policy

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|---|---|
| Post holder responsible for Procedural Document | Melanie Holley<br>Head of Governance |
| Author of Policy | Melanie Holley<br>Head of Governance |
| Division/ Department responsible for Procedural Document | Corporate Affairs |
| Contact details | x3933 |
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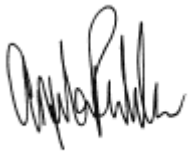
| Date document becomes live | 21st April 2015 |

| Please *specify* standard/criterion numbers and tick other boxes as appropriate | | | |
|---|---|---|---|
| **Monitoring Information** | | **Strategic Directions – Key Milestones** | |
| Patient Experience | | Waiting | |
| Assurance Framework | | Privacy and Dignity | |
| Monitor/Finance/Performance | | Efficiency and Effectiveness | |
| CQC Regulations/Outcomes: | **Outcome 16** | Delivery of Care Closer to Home | |
| | | Infection Control | |
| NHSLA Risk Management Standards for Acute Trusts | | | |
| NHSLA CNST Maternity Clinical Risk Management Standards: | | | |
| Other *(please specify)*: | | | |
| **Note:** This policy has been assessed for any equality, diversity or human rights implications | | | |

| Full History | | Status: Final | |
|---|---|---|---|
| Version | Date | Author (Title not name) | Reason |
| 1.0 | 21/06/2012 | Senior HR Manager | *Minor amends/due for review* |
| 2.0 | 31/01/2013 | Senior HR Manager | *Minor amends* |
| 3.0 | 30/07/2014 | Head of Governance | *Due for routine review* |
| 4.0 | 21/04/2015 | Head of Governance | *Minor amendment: change of Medical Director's name and contact details in 5.4, following previous MD's retirement. Amendment approved by Governance Committee Chair on 20/04/2015.* |

| | |
|---|---|
| **Associated Policies:** | Counter Fraud Policy<br>Disciplinary and Appeals Policy<br>Personal and Related Persons Policy and Procedure<br>Equality and Diversity Policy<br>Grievance Policy<br>Health and Safety Policy<br>Incident Reporting, Analysing, Investigating and Learning Policy and Procedures<br>Prevention of Harassment and Bullying at Work Policy |
| **In consultation with and date:**<br>Assistant Directors of Nursing, Chairman, Chair of Medical Staff Committee, Deputy Chief Nurse and Midwife, Deputy to Director of Transformation and Organisational Development, Director of Operations, Divisional Directors, Executive Directors, Governance Committee (Members of), Governance Managers, Joint Staff Committee (JSCNC), Trust Solicitors: 25th September 2014.<br>Policy Expert Panel (PEP): 3rd November 2014<br>Governance Committee: 10th October 2014<br>Governance Committee Chair's approval: 20th April 2015 | |
| **Review Date** *(Within 3 years)* | April 2017 |
| **Contact for Review:** | Head of Governance |
| **Executive Lead Signature:**<br>*(Only applicable for Strategies & Policies)* |  <br>Chief Executive |

## CONTENTS

## 1. INTRODUCTION

1.1 Employees at one time or another may have concerns about what is happening at work. Usually these concerns are easily resolved. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues or the Royal Devon & Exeter NHS Foundation Trust (hereafter referred to as "the Trust") itself, it can be difficult to know what to do.

1.2 Examples of serious concerns:

- A criminal offence has been committed, is being committed or it likely to be committed.
- A person or the Trust has failed, is failing, or is likely to fail to comply with any legal obligation.
- A miscarriage of justice has occurred, is occurring or is likely to occur.
- The health and safety of an individual has been, is being, or is likely to be endangered.
- The environment has been, is being, or is likely to be damaged.
- Past or future deliberate concealment of any of the above.

1.3 You may be worried about raising concerns like the ones above, or you may want to keep the concerns to yourself, perhaps feeling that it is none of your business, or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or to the organisation. You may decide to say something but find that you have spoken to the wrong person, or raised the concern in the wrong way, and are not sure what to do next.

1.4 The Trust is committed, in all its activities, i.e. conducting its business, delivering care to patients, and the management of its staff, to undertake these activities to the highest possible standards. In order to fulfil this commitment, all staff are encouraged to raise concerns.

1.5 Concerns should be raised direct with the line manager at a local level and at the earliest opportunity. Where the employee, for whatever reason, does not feel this is possible (or where the employee has followed this route and has not been satisfied with the outcome), the concern should be directed to one of the Trust's Executives, listed in section 5 of this policy.

1.6 If in doubt, follow the policy.

## 2. PURPOSE

2.1 The Trust has produced this policy to encourage staff to raise all concerns and to provide a clear framework so that staff know the correct way in which to raise a concern at the earliest opportunity. The policy will provide a framework for ensuring that all concerns are logged, recorded, escalated to the correct person, taken seriously, and the appropriate management action is undertaken without delay.

2.2 By implementing this policy, the Trust aims to protect employees from being subjected to a detriment by the Trust for making a protected disclosure. In so-doing, the Trust is complying with the Employment Rights Act 1996 and the Public Disclosure Interest Act 1998.

2.3 This policy is not applicable to concerns which relate to an individual's personal employment, terms and conditions, or how a member of staff has been treated. These concerns fall within the remit of other Trust policies, and staff who use the Whistleblowing Policy to raise such concerns will be re-directed to the Human Resources (HR) Department, and the correct policy, such as the Grievance Policy, the Prevention of Harassment and Bullying at Work Policy and the Disciplinary and Appeals Policy**.**

## 3. DEFINITIONS

3.1 **Whistleblowing –** is a term used when someone who works within, or has worked within, an organisation discloses information that they reasonably believe is in the public interest to disclose - and which they reasonably believe could demonstrate the commission of crimes, breaches of legislation, miscarriages of justice, dangers to health and safety and the environment - or the concealment of information on any of these.

3.2 **Whistleblower** - is an individual who discloses information (as detailed above).

3.3 **Serious Concern** – a matter of grave importance with far-reaching implications. Examples are outlined on page 1, paragraph 1.2.

3.4 **Grievance –** a complaint against an employer by an employee, for a contractual violation.

3.5 **Anonymity/anonymous** - is where an individual does not identify him or herself to anyone.

3.6 **Member of staff** - any individual who is employed within the Trust, including full and part-time workers, fixed-term contracts, bank, agency, trainees and contractors. (for the avoidance of doubt, Whistleblowing concerns received from ex-members of staff will be managed in the same way).

## 4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **The Chief Executive** is responsible for ensuring that the Trust conducts its business appropriately, in line with legislation and the requirements of its Regulators (The Care Quality Commission (CQC) and Monitor).

4.2 The Chief Executive is responsible for the overall implementation of this policy. The Chief Executive is responsible for informing the Trust Chairman and Chair of the Governance Committee (GC) of Whistleblowing concerns received and for presenting the outcome from Whistleblowing investigations to the GC.

4.3 **The Trust Chairman** is responsible for the leadership and effectiveness of the Board of Directors and the Council of Governors and ensuring that these two components of the Trust's governance arrangements work together effectively. The Chairman is responsible for receiving and processing appeals made under this policy.

4.4 **Chief Nurse/Chief Operating Officer** is responsible for the leadership of the nursing, midwifery and Allied Health Professional workforce and for the delivery of general management, strategic and professional responsibility for the Trust's operational delivery. The Chief Nurse/Chief Operating Officer is responsible for receiving concerns from employees who feel unable to report through their line manager.

4.5 **Medical Director** is responsible for the leadership of the medical workforce. The Medical Director is responsible for receiving concerns from employees who feel unable to report through their line manager.

4.6 **Director of Finance and Business** is responsible for leading and co-ordinating the development and implementation of the Trust's corporate strategy, and ensuring the Trust meets the financial requirements of the Foundation Trust regulator. The Director of Finance is responsible for receiving concerns from employees specifically in relation to suspected or alleged fraud.

4.7 **Non-Executive Director, Chair of Governance Committee t**he Lead Non-Executive Director for this policy is responsible for supporting the Chief Executive and the Head of Governance to provide an "independent view" when requested.

4.8 **Head of Governance (HoG)** is responsible for ensuring that the Trust has in place sound integrated governance policies, procedures and structures, and complies with its legal, constitutional and regulatory requirements.

4.9 The HoG are responsible for providing independent and expert advice in terms of the enactment of this policy. In addition, the HoG will ensure that a central log of all Whistleblowing concerns is created and maintained, and will provide support to the Executive Team in relation to the enactment of the policy.

4.10 **Employees** are responsible for raising concerns direct with their line manager at the earliest opportunity. Where the employee has followed this route and has not been satisfied with the outcome, the concern should be directed to one of the Trust's Executives, listed in section 5.4.

4.11 **Line Managers** are responsible for managing any concerns raised by staff promptly. Where a serious concern has been raised, Line Managers should share a copy of the concern with their Head of Department who will share with one one of Trust's Executive, listed in section 5.4.

4.12 **Investigating Officer/Investigating Team** are responsible for undertaking investigations/fact finding exercise as requested ensuring that the terms of reference are followed.

4.13 **Governance Committee (GC)** is responsible for ensuring that governance is embedded in the organisation and that the Trust operates within the law and complies with its regulators and delivers safe, quality and effective care. It provides assurance to the Board of Directors that the Trust has effective systems of internal control in relation to risk management and governance.

4.14 The GC will receive, from the Chief Executive, notifications of whistleblowing concerns and the outcome of any subsequent investigations. The GC is responsible for ensuring that a robust process has been followed, in line with the Whistleblowing Policy, to enable assurance to be provided to the Board of Directors. In the event that the GC identifies through the investigation process, a gap in assurance, the GC

is responsible for monitoring management action until its completion, thus reducing the risk of the same/similar Whistleblowing concerns being raised and proven.

4.15 **Devon and Cornwall Local Counter Fraud Service (LCFS)** is responsible for receiving referrals from anyone with concerns about fraud and/or corruption in the NHS. The (LCFS) will review the information received and if there is evidence of fraud will investigate the matter.

## 5. HOW TO RAISE A SERIOUS CONCERN

5.1 In the first instance, any concern should be raised directly by the individual with their line manager.

5.2 Concerns can be raised verbally, face-to-face, or in writing. Staff have the right, but are encouraged not to remain anonymous. This is because anonymity makes it difficult to investigate the concern without the benefit of seeking and clarifying information. It also means that assurance cannot be given to the individual that a thorough and robust process has been followed, or, indeed, the outcome. (A facility is available on Datix to report concerns anonymously).

5.3 Concerns received anonymously will be managed in line with the spirit of the Whistleblowing Policy, but will be considered on a case-by-case basis, taking into account both the seriousness and level of information contained within the communication. The decision regarding the appropriate action to be taken in relation to an anonymous concern will be made by two Executive Directors and the HOG.

5.4 If an individual, having raised a concern with his/her line manager, does not feel that they have received a satisfactory outcome, or, in the event where, for whatever reason, the individual does not feel able to raise a concern with his/her line manager – the concern can be raised directly with their Head of Department who will share with in writing to any one of the following:

- Em Wilkinson-Brice
  Chief Nurse/Chief Operating Officer
  E215
  Royal Devon & Exeter NHS Foundation Trust
  Barrack Road
  Exeter EX2 5DW
  01392 403947 em.wilkinson-brice@nhs.net

- Adrian Harris
  Medical Director
  E214
  Royal Devon & Exeter NHS Foundation Trust
  Barrack Road
  Exeter EX2 5DW
  01392 403803 adrianharris1@nhs.net

- Suzanne Tracey *(in particular where fraud is suspected or being committed)*
  Director of Finance and Business Development
  E210
  Royal Devon & Exeter NHS Foundation Trust
  Barrack Road
  Exeter EX2 5DW
  01392 402362 suzanne.tracey@nhs.net

*or*

- Tracy Wheeler
  Local Counter Fraud Specialist
  Audit South West Counter Fraud Service
  Newcourt House
  Old Rydon Lane
  Exeter EX2 7JU
  01752 431378/0778 986 8568 tracy.wheeler2@nhs.net

5.5 If the concern being raised is in relation to an Executive Director, or the Chief Executive, these should be made in writing to:

- James Brent
  Chairman
  E209
  Royal Devon & Exeter NHS Foundation Trust
  Barrack Road
  Exeter EX2 5DW
  01392 403928 james.brent@nhs.net

*or*

- Michele Romaine
  Non-Executive Director, Chair of the Governance Committee
  E221A
  Royal Devon & Exeter NHS Foundation Trust
  Barrack Road
  Exeter EX2 5DW
  01392 404551 michele.romaine@hotmail.co.uk

5.6 Whilst the Trust strongly encourages staff to raise concerns internally, external independent advice can be sought from the following:

- If applicable, a staff side representative (Union) or professional body, e.g. the Nursing and Midwifery Council (NMC)
- The independent charity, Public Concern at Work, which has lawyers who provide free, confidential advice.
- Either of the Trust's Regulators:
  - CQC
  - Monitor

## 6. WHAT WILL HAPPEN ONCE A CONCERN HAS BEEN RAISED?

*(See Appendix 1: Flow Chart, and Appendix 2: Management Guidelines)*

6.1 On receipt of a Whistleblowing concern, the appropriate Executive Director and the HoG will:

- Date stamp and log receipt of the Whistleblowing concern on the central Whistleblowing database.

- Inform the Chief Executive, Chairman, and the Chair of the GC that a Whistleblowing concern has been received.

- Arrange a meeting with the Whistleblower, within 7 days of receipt of the letter, to discuss the concern, and clarify any immediate points. The Whistleblower will also be asked what outcome he/she is expecting from the process.

- If the Whistleblowing concern is anonymous, prior to a decision being made on how to proceed, a validation exercise and risk assessment (as outlined in the management guideline in Appendix 2,) will be undertaken. .

- Assess and agree, in line with the policy and management guidelines, what action should be taken, e.g. internal investigation.

- Ensure that any such actions are undertaken, thoroughly and timely, to avoid delays.

- Write to the Whistleblower to acknowledge receipt of the concern and to advise who will be leading the investigation, what further input might be required from the individual, and approximate timeframes.

- Where the concern being raised does not fall within the remit of this Policy, write to the Whistleblower providing advice and re-direction to the appropriate Department and Policy, e.g., HR: Grievance Policy.

- **On conclusion of any action/investigation:**

    - The Executive Director and the HoG will inform the Chief Executive and the Chairman. The Chief Executive will subsequently inform the GC of the outcome, and, where appropriate, identify lessons learnt and areas for further action.

    - The Executive Director will write to the Whistleblower advising of the outcome and findings, sharing any lessons learnt and areas for further action. The Whistleblower will be given the option to meet with the Lead Executive Director and HoG to discuss the outcome.

    - Advise the Whistleblower of his/her right to appeal the outcome and the process to be followed. (See section 7.)

    - Close down the Whistleblowing log.

## 7. RIGHT TO APPEAL / FURTHER ADVICE

7.1 Whistleblowers have the right of appeal if they believe the process followed was not as described in this policy. Any such appeal should be made in writing, to the Trust Chairman within 14 days of receipt of the conclusion of their whistleblowing concerns.

## 8. ARCHIVING ARRANGEMENTS

8.1 The original of this policy will remain with the author, the Head of Governance, Corporate Affairs. An electronic copy will be maintained on the Trust Intranet (IaN), P – Policies – W – Whistleblowing, and C – Concern. Archived copies will be stored on the Trust's "archived policies" shared drive, and will be held for 10 years.

8.2 Whistleblowing letters and reports will be held electronically by the Head of Governance and will be held for 10 years.

## 9. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

9.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

| No | Minimum Requirements | Evidenced by |
|---|---|---|
| **1.** | Audit a sample of concerns received and managed in line with this policy bi-annually. | Whistleblowing log, investigation reports, papers submitted to the Governance Committee. |

9.2 **Frequency**
Bi-annually Internal Audit will be asked to review compliance against the policy by reviewing a sample of concerns received. The formal report will be presented to the Chief Executive and Executive Lead and the Head of Governance. The outcome of the audit will be presented to the Governance Committee.

9.3 **Undertaken by**
Internal Audit Department.

9.4 **Dissemination of Results**
At the Governance Committee, which meets six times a year.

9.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Governance Committee, which meets six times a year.

9.6 Any barriers to implementation will be risk-assessed and added to the risk register.

9.7 Any changes in practice needed will be highlighted to Trust staff via the Trust's Senior Management structure and via the "Must Reads" section on IaN.

## 10. REFERENCES

*Employment Rights Act 1996*. (c.18). London: Stationery Office. Available at: http://www.legislation.gov.uk/ukpga/1996/18/contents [Accessed 07/09/2014]

*Public Disclosure Act 1998*. (c.23). London: Stationery Office. Available at: http://www.legislation.gov.uk/ukpga/1998/23/contents

[Accessed 07/09/2014]

Care Quality Commission (CQC). Available at: http://www.cqc.org.uk/
[Accessed 07/09/2014]

Monitor. Available at:
https://www.gov.uk/government/organisations/monitor
[Accessed 07/09/2014]

Nursing and Midwifery Council (NMC). Available at:
http://www.nmc-uk.org/ [Accessed 07/09/2014]

Public Concern at Work. Available at:
http://www.pcaw.co.uk/ [Accessed 07/09/2014]

## 11. ASSOCIATED TRUST POLICIES

Counter Fraud Policy

Disciplinary and Appeals Policy

Personal and Related Persons Policy and Procedure

Equality and Diversity Policy

Grievance Policy

Health and Safety Policy

Incident Reporting, Analysing, Investigating and Learning Policy and Procedures
Prevention of Harassment and Bullying at Work Policy

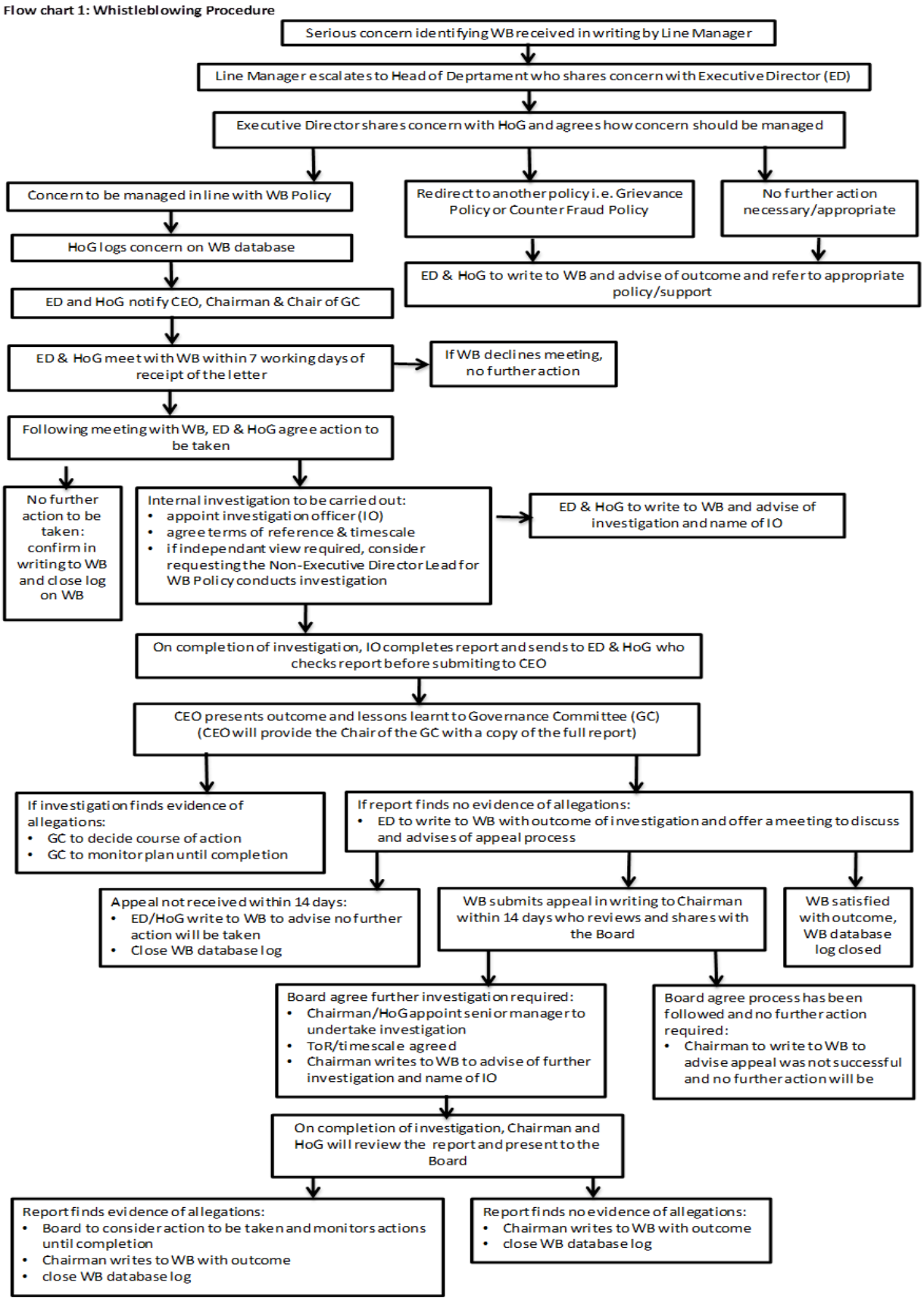
## 12. OTHER ASSOCIATED DOCUMENTS

Department of Health (2013*). NHS Constitution for England, 2013*. London: DoH [online]. Available at:
https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[Accessed 07/09/2014]

NHS England (2013*). Standing Financial Instructions*. NHS Commissioning Board [online only]. Available at:
http://www.england.nhs.uk/wp-content/uploads/2013/11/fin-0001-v3.pdf.
[Accessed 07/09/2014]

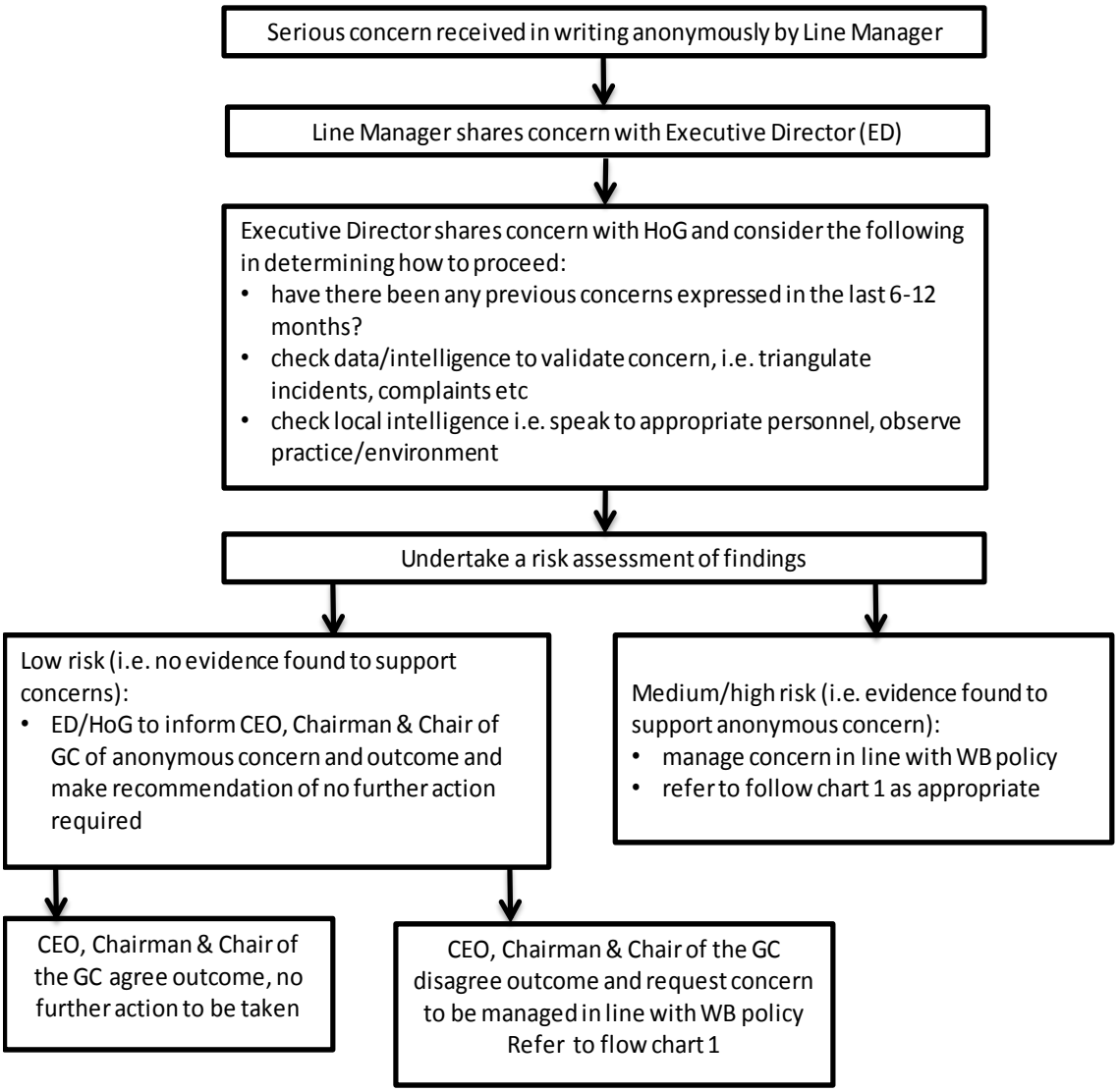
## APPENDIX 1: FLOWCHARTS 1 & 2

### Flowchart 1: Whistleblowing Procedure



## Flowchart 2: Anonymous Whistleblowing Procedure

**Flow chart 2: Anonymous Whistleblowing Procedure**



## APPENDIX 2: MANAGEMENT GUIDELINES

### Management guidelines

### 1. GENERAL

1.1 These guidelines are to be used in conjunction with the Whistleblowing Policy and are designed to guide managers through the process. There is also a flow chart (Appendix 1) to show the process.

1.2 Upon receipt of a concern line managers have a duty to act on this promptly. Please share a copy of the concern with one of the following:

- Chief Executive
- Chief Nurse/Chief Operating Officer
- Medical Director
- Director of Finance and Business (for concerns specifically in relation to suspected or alleged fraud)

1.3. On receipt of the concern, the nominated Executive Director will share the details with the HoG and they will decide how the concern should be managed, i.e.:

- In line with this policy (Whistleblowing)
- Redirected to another policy (Grievance, or Harassment and Bullying)
- If suspected fraud, in line with this policy and the Trust Counter Fraud Policy.
- No action necessary – issue has already resolved, or there is insufficient information to take the matter further.

1.4 If the concern has been made anonymously – the following should be considered/explored prior to a decision being made on how to proceed:

- In the last 6-12 months, have there been any previous concerns expressed in line with the concern?

- Check data/sources of intelligence to triangulate – i.e. incidents and complaint data, CQAT, Safety thermometer etc.

- Check out, on a local level whether there is any other cause for concern, e.g. discussing with line manager, or observation of practice.

- Undertake a risk-assessment

1.5 If the decision is made to manage the concern in line with the Whistleblowing Policy, the Executive Director and HoG will notify the Chief Executive and the Chairman. The communication will include an outline of the concern and the proposed action and timeframe. The Chief Executive will notify the Trust Chairman and the Chair of the Governance Committee.

1.6 At any stage, the Executive Director and HoG may request a Non-Executive Director or independent person oversees the process, or provides an “independent” view. This request will be made to the Chief Executive who will agree the next steps with the Trust Chair and Chair of Governance Committee.

1.7 If the Executive Director and HoG make a recommendation not to investigate, the Chief Executive shall review and make a final decision.

1.8 The Executive Director and HoG will notify the Whistleblower of the proposed action.

1.9 The Chief Executive will report the decision to the Governance Committee.

## 2. INVESTIGATION REQUIRED

2.1 If it is decided that an investigation is required the Executive Director and HoG will nominate an investigator (or investigation team) and agree the terms of reference for the investigation, together with the timeframe for commencing and concluding the investigation.

2.2 Consideration will be given as to whether an external investigator/specialist advisor is appropriate. Similarly, a decision may be taken that in addition to an investigation, external assurance may be sought, i.e. peer review, independent review etc.

2.3 The Executive Director and HoG will notify the Whistleblower the name of the investigator (or lead investigator), and provide contact details.

## 3. INVESTIGATION PROCESS

3.1 The investigator will arrange to meet with the Whistleblower to hear the concern. The meeting should be managed in line with the Trust's HR investigation process.

- The Whistleblower must be offered rights of representation during the meeting (and any subsequent meetings) – entitlement is to a staff side representative or workplace colleague.

- Notes of the meeting should be taken – with draft copies being provided to the Whistleblower as soon as possible after the meeting to allow for accuracy-checking.

- Amendments to notes should be handwritten on the draft, and the Whistleblower will be given the opportunity to add, on a separate page, any additional information, not volunteered at the meeting. On completion, the notes should be signed, and dated and returned to the investigator.

- In line with the terms of reference of the investigation, the investigator has the right to interview staff, observe practice, access information and undertake any other appropriate activity that will help to reach an outcome for the investigation.

3.2 On completion of the investigation, a report will be written at the earliest opportunity (using the template, Appendix 3), and submitted to the Executive Director and HoG. The Executive Director and HoG will review the report to ensure that the Terms of Reference have been met, and to consider whether any further investigation is required.

3.3 The investigation process from start to completion should be undertaken in a timely manner without delay.

3.4 The report will then be submitted to the Chief Executive, who will share a full copy of the report with the Chair of the GC. The Chief Executive will inform the Governance Committee of the outcome, and, where appropriate, will identify lessons learnt, and areas for further action.

3.5 The Executive Director will write to the Whistleblower with the outcome of the investigation, and offer a meeting to discuss the findings and outcome.

3.6 In the event that the investigation finds evidence of the allegations, the Governance Committee will consider any action to be taken. (In the event of potential delay caused by scheduling of the Governance Committee, a copy of the report will be provided in the first instance to the Chair of the Governance Committee).

3.7 In the event that the Governance Committee request action to be taken, details of the decision of the Governance Committee will be communicated with the Whistleblower, where appropriate.

## 4. RIGHT OF APPEAL

4.1 The Whistleblower has the right of appeal if he/she does not believe that the process within the Whistleblowing Policy has been followed. If the Whistleblower wishes to appeal, this should be put in writing, and addressed to the Chairman within 14 days of the receipt of the outcome letter.

4.2 On receipt of the appeal against the process, the Chairman will discuss the case and the outcome of the investigation with the Board of Directors in order to seek a collective view on whether the Board of Directors feel that the investigation was undertaken in line with the process or not. The Board of Directors have the right to request further investigation.

4.3 In the event that further investigation is deemed necessary and appropriate, the Chairman and the Head of Governance will jointly agree an appropriate senior manager to undertake the further investigation. This will not be the same investigating officer or team as the original investigation. If appropriate, a new (different) set of Terms of Reference will be agreed, together with an appropriate timeframe, to ensure that the concerns are investigated without further delay.

4.4 On completion of the investigation, a report will be written at the earliest opportunity (using the template, Appendix 3) and submitted to the Chairman and HoG.

4.5 The Chairman and HoG will review the report to ensure that the Terms of Reference have been met and to consider whether any further investigation is required.

4.6 The report will be presented by the Chairman to the Board of Directors. In the event that any of the allegations are upheld, the Board of Directors will consider any action to be taken.

4.7 The Chairman will write to the Whistleblower with the outcome of the second investigation (and, if appropriate, details of any action to be taken.)

4.8 There is no further right of appeal against the process or decision.

4.9 If, following the conclusion of the Whistleblowing process, the outcome reached is that the Whistleblower was malicious and that disciplinary action should follow, the matter should be referred to the HR Department before any disciplinary action is taken, to ensure that there is no breach of employment legislation.

**APPENDIX 3: INVESTIGATION REPORT TEMPLATE**

Royal Devon and Exeter NHS
NHS Foundation Trust

# WHISTLEBLOWING INVESTIGATION REPORT

| | | |
|---|---|---|
| Investigating Manager: | | |
| HR Lead: | | |
| Date of Commencement of Investigation: | | |
| Employee being investigated | Name | |
| | Band/ Job title | |
| | Current line manager | |

**Allegation/Incident that lead to the requirement for investigation**

This investigation was undertaken in line with the Trust's Whistleblowing Policy in relation to concerns raised in writing by

A copy of the letter is attached at Appendix 1.

In summary the letter contained allegations relating to the following areas of serious concern grouped under the issues below:

**Context of the Investigation / Terms of Reference**

**Investigation process and methodology**

Investigatory Interviews Undertaken:

| Name | Job Title | Date |
|---|---|---|
| | | |
| | | |
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| | | |

**Findings of the Investigation**

Of the X areas of concern raised by the XX the investigation has found the following:

**Allegation1:**

Finding:

**Allegation 2:**

Finding:

**Summary**

The investigation *could / could not* find support the allegations

The investigation has thoroughly explored the issues raised in the letter dated xxx. The conclusion from the investigation:

Allegations numbered and substantiated claim or not 1 - not substantiated

The Trust should be assured that a robust and thorough investigation has been carried out in line with the Whistleblowing Policy.

| **Wider learning** |
| --- |
| **Observation:**<br><br>Recommendation |
| **Date Investigation closed:** |
| Report submitted to : |
| **Appendices**<br>Appendix 1: Copy of letter<br>Appendix 2: Investigation Chronology<br>Appendix 2: Confidential draft example of questions |

## APPENDIX 4: SAMPLE LETTER OF RESPONSE TO WHISTLEBLOWER

### Sample Letter of response to Whistleblower

Dear

I am writing to confirm receipt of your letter/your concern which has been raised verbally/in writing, (delete as appropriate) dated ……. in which you have formally raised concerns regarding……

After consideration of the concern that you have raised I have made the decision that
EITHER:
a) the concerns you have raised fall more appropriately within the Grievance/Dispute Resolution Policy and Procedure (copy attached), and if you wish to take the matter further you should follow the process outlined in that document.

You can talk this through in more detail with a member of the Head of Specialist Human Resource Services, who will be able to talk through the process with you.

OR

b) I believe that your concern warrants a formal investigation and I have asked ……. to lead this investigation with a nominated Human Resources representative. They will contact you shortly to arrange to meet with you and hear the detail of your concern as part of this investigation.

Following the initial meeting with yourself, and any appropriate investigations, which will be decided upon by the Investigating Officer, a report will be prepared and returned to the Chief Executive. He/ She will then consider whether they believe a thorough investigation has been undertaken or whether they require any further actions to be undertaken.

Once the Chief Executive is satisfied with the extent of the investigation he/she will write to you and confirm the outcomes of the investigation and where appropriate any corrective actions that are to be undertaken as a result of your raising your concerns. Please note we may not be able to tell you the precise actions which are taken where this would infringe a duty of confidence owed to another person.

At any formal meeting with the investigatory team you may of course be accompanied at the hearing by either a staff side representative or workplace colleague.
If you have any queries about the content of this letter, please let me know.

Finally I would like to take this opportunity to thank you for raising this concern. Please do not hesitate to contact me if you have any further questions or if you would like to consider accessing support from the Occupational Health Department.

Yours sincerely

## APPENDIX 5: SAMPLE LETTER TO WHISTLEBLOWER ENCLOSING NOTES OF INVESTIGATORY MEETING

### Sample letter to Whistleblower enclosing notes of investigatory meeting

Dear

Thank you for attending the meeting on …… in connection with your concern regarding……..

I enclose a copy of the notes of the meeting for your retention. I would be grateful if you would read and sign the second copy of the notes and return it to me to confirm that you feel the notes are accurate. If you wish to make any amendments, please do so in ink, and initial each change. I would remind you that the notes are not verbatim and should form an overview of the discussions on the day and not any subsequent views. If however you have any supplementary information that you wish to give you may add this on a separate piece of paper and attach it to the notes.

Please return these notes within 1 week of receipt of the letter. If not received from you by *(insert date*), I will assume that you believe the content to be correct and accurate.

Please let me know if you have any questions or concerns.

Yours sincerely

**APPENDIX 6: RAPID IMPACT ASSESSMENT SCREENING FORM**

# RAPID IMPACT ASSESSMENT SCREENING FORM

| | |
|---|---|
| **Name of procedural document** | Whistleblowing (or How to raise a Concern) Policy |
| **Division/Directorate and Service Area** | Corporate Affairs |
| **Name, job title and contact details of person completing the assessment** | Melanie Holley<br>Head of Governance<br>Ext. 3933 |
| **Date:** | 25th August 2009<br>Reviewed 7 June 2012<br>Reviewed 26 September 2014 |

## EXECUTIVE SUMMARY

This policy does not have any equality impacts.

It is all-inclusive (covering all who work at the Trust) and well designed to meet any individual support needs which could arise.

1. **What is the main purpose of this policy / plan / service?**
   To provide an effective and safe way for staff to raise concerns about any aspects of the Trust's business and service delivery.

2. **Who does it affect?** .
   Staff

**3. What impact is it likely to have on different sections of the community / workforce, considering the "protected characteristics" below?**

**Please insert a tick in the appropriate box ✓**

| Protected Characteristics | Positive impact -- it could benefit | Negative impact -- it treats them less favourably or could do | Negative impact -- they could find it harder than others to benefit from it or they could be disadvantaged by it | Non-impact – missed opportunities to promote equality | Neutral -- unlikely to have a specific effect |
|---|---|---|---|---|---|
| Age | ☐ | ☐ | ☐ | ☐ | ✓ |
| Disability | ☐ | ☐ | ☐ | ☐ | ✓ |
| Sex *including Transgender and Pregnancy / Maternity* | ☐ | ☐ | ☐ | ☐ | ✓ |
| Race | ☐ | ☐ | ☐ | ☐ | ✓ |
| Religion / belief | ☐ | ☐ | ☐ | ☐ | ✓ |
| Sexual orientation including Marriage / Civil Partnership | ☐ | ☐ | ☐ | ☐ | ✓ |

In identifying the impact of your policy across these characteristics, please consider the following issues:

- **Fairness -** Does it treat everyone justly?
- **Respect -** Does it respect everyone as a person?
- **Equality -** Does it give everyone an equal chance to get whatever it is offering?
- **Dignity -** Does it treat everyone with dignity?
- **Autonomy -** Does it recognise everyone's freedom to make decisions for themselves?

4. **If you have identified any positive impacts (see above), what will you do to make the most of them?**

| "Protected characteristic" affected: | | |
|---|---|---|
| Issue | | |
| Who did you ask to understand the issues or whose work did you look at? | What did you find out about? | What did you learn or confirm? |
| | | |
| Action as a result of above | | |
| Action | By who? | When? |
| | | |

5. **If you have identified any missed opportunities ("non-impacts"), what will you do to take up any opportunities to promote equality?**

| "Protected characteristic" affected: | | |
|---|---|---|
| Issue | | |
| Who did you ask to understand the issues or whose work did you look at? | What did you find out about? | What did you learn or confirm? |
| | | |
| Action as a result of above | | |
| Action | By who? | When? |
| | | |

6. **If you have identified a neutral impact, show who you have consulted or asked to confirm that this is the case, in the table below:**

| Who did you ask or consult to confirm your neutral impacts?<br>(Please list groups or individuals below. These may be internal or external and should include the groups approving the policy.) |
|---|
| Assistant Directors of Nursing<br>Chairman<br>Chair of the Medical Staff Committee<br>Deputy Chief Nurse and Midwife<br>Deputy to Director of Transformation and Organisational Development<br>Director of Operations<br>Divisional Directors<br>Executive Directors<br>Governance Committee (Members of)<br>Governance Managers<br>Joint Staff Committee (JSCNC)<br>Policy Expert Panel (PEP)<br>Trust Solicitors |