

THE FREEDOM TO SPEAK UP REVIEW

Sir Robert Francis QC

SUBMISSION

by

Patients First

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SUMMARY

- (1) **This Submission:** This submission is evidence-based and seeks to provide a fair view across a significant number of cases (70 individual cases collated and thematically reviewed – some respondents wishing to remain anonymous, but known to Patients First). This submission seeks to put that thematic review into fair context using (a) the combined experience of those on the ‘Team’ working on this submission and (b) the backdrop of an analysis of material in the public domain. All those in the Team who have worked on this submission, over the last two months, have done so *pro bono*.
- (2) **Assisting the Review:** This submission is very much a high level summary intended to assist, but not burden, the Review. Further supporting or related material can be provided in relation to any points upon which it might be welcome or helpful. Furthermore, Patients First holds a list of those who are prepared to speak to the Review directly, if asked, on any particular points.
- (3) **Continuing problem:** There is a real and continuing problem over the treatment of those who raise concerns (typically as required by the professional duties). Notably, the divergence between best practice and the norm (and indeed, worst practice) appears to be getting greater – demonstrating that there are examples of good practice which work and that this is not insoluble.
- (4) **Fundamental error:** Some NHS employers are working to a fundamentally wrong definition of whistleblower (see: Annex 2). Further, failure to provide support, correctly to characterise those who raise concerns and to follow policies appears to be the norm rather than the exception. This is not easy to reconcile with some statements by employers that the problem is (a) well understood and (b) being addressed appropriately.
- (5) **Confidentiality, isolation and vulnerability:** Directly contrary to some of the policy objectives behind legal protection of whistleblowers, processes adopted typically lead to the isolation of whistleblowers and the ‘containing’ of their concerns – e.g. through confidentiality imposed during internal or supposedly independent investigations, through suspension, through restrictions on the use of documents provided in disclosure (in ET proceedings). The sense of isolation and uncertainty contributes to the vulnerability felt by many whistleblowers, already on a very unequal footing.
- (6) **Expertise and experience:** The predominance of those of significantly greater expertise or experience was a very striking feature. Greater expertise and experience may provide the insight or ability to spot what is going wrong or may contribute to the confidence to raise concerns in the first place: we could not form a view about this, but both appear realistic.

- (7) **Loss to the NHS:** A very striking feature of the thematic review was the loss of trained talent to the NHS, through termination of employment, ill health or, in some cases, suspension on full pay for long periods. This feature was particularly striking in the light of the *expertise and experience* of those concerned (identified at point (6) above).
- (8) **Law ineffective:** There were numerous examples of the law being ineffective to protect whistleblowers. The protection afforded by the law (such as it is) is very much after the event and retrospective. Interim relief (under s.128 ERA) is only available *after* dismissal – itself far too late – and in the sample of 70 cases, was obtained in only 2 cases. The inequality of financial resources between whistleblower and employers was starkly apparent.
- (9) **Culture of fear:** There seems little doubt that the examples of those who raise concerns, and their treatment thereafter, would and does operate as a serious deterrent to those who might wish (or feel bound by their professional duties) to raise such concerns. The de-commissioning of troublesome units was also anecdotally reported. There are examples of people stopping raising very serious concerns, out of fear for how they will be treated, although the thematic review behind this submission was, by definition, limited to those who *did* raise their concerns.
- (10) **Professional bodies & disciplinary referrals:** The number of referrals of whistleblowers to their professional bodies was also striking. An overwhelming number were dismissed by professional bodies at a preliminary stage on the basis that there was no case to answer – calling into question the basis and motive for employers having made such referrals. Others faced years of distress, marginalisation and expense, before finally being acquitted of any professional misconduct. Professional bodies do not seem to have the institutional vocabulary, systems or will to support whistleblowers or to recognise the difficulties (and potential conflicting obligations) faced by those who raise concerns.

Definition of Whistleblowing

‘Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called ‘making a disclosure in the public interest’.

([Source: www.gov.uk/whistleblowing/overview](http://www.gov.uk/whistleblowing/overview))

“A worker can report things that aren’t right, are illegal or if anyone at work is neglecting their duties, including: someone’s health and safety is in danger; damage to the environment; a criminal offence; the company isn’t obeying the law (like not having the right insurance); covering up wrongdoing.”

This largely mirrors the Public Interest Disclosure Act provisions (‘PIDA’) inserted into the Employment Rights Act (save the report can also be about a breach of duty that is *likely to happen*, and must be reasonably believed to be in the public interest). PIDA makes no distinction between “raising concerns” and “whistleblowing” and no distinction between whether the concerns are raised internally or externally (cf. NHS Employers at Annex 2). What counts is whether the concern reported falls within any of the categories set out above.

RECOMMENDATIONS

- I. A full list of recommendations is set out in Annex I (at page 33). By way of overview, it seems important that changes are required as a matter of some urgency in order to achieve the following:-
 - (1) **Early support:** Ensure early support of whistleblowers in the normal course of employment.
 - (2) **Approach of Employers:** Ensure that NHS employers approach the issue on the basis of a correct, rather than fundamentally flawed, understanding of the PIDA provisions and the scope of protection that they (and perhaps more importantly, internal NHS procedures) should afford to those who raise concerns.
 - (3) **Avoid distraction:** Avoid distraction from patient safety concerns into employment issues.
 - (4) **Culture change:** Effect culture change amongst those who typically deal with whistleblowers, including unions and others, to ensure proper understanding and support.
 - (5) **Prevent isolation & 'containment':** Encourage transparency and change policies and processes that lead to marginalisation and isolation of whistleblowers and the 'containing' of their concerns (the latter e.g. by the veil of *ad hoc* confidentiality or by 'gagging clauses').
 - (6) **Professional and regulatory bodies:** Ensure that professional and regulatory bodies: (a) play a concrete and positive role in supporting whistleblowers (and the changes necessary to achieve the above); and (b) are astute to detect reactive or malicious referrals for professional misconduct, and have policies in place to identify and deal with them appropriately. Introduce appropriate regulatory reporting requirements for employers that would catch real whistleblowing disputes early.
 - (7) **Legal protection:** Amend the existing legislation to give whistleblowers more legal protection at or about the time they make the disclosure, rather than a speculative (and unpredictable) chance of some compensation for (e.g.) a ruined professional life and career and several years of loss of earnings.

ABOUT THIS SUBMISSION

PATIENTS FIRST

2. Patients First is a network of health professionals (and their supporters) who have made patients their first concern by raising concerns about poor standards of care and unsafe practice and in doing so, have often suffered reprisals in the workplace for highlighting such concerns. Its members are nurses, doctors, managers and other staff in the NHS. Patients First aims actively to support those who raise issues of patient safety.

SCOPE OF THIS SUBMISSION

3. In compiling this submission, Patients First has sought to respect the limits of *The Freedom to Speak Up Review*:

“This Review is not about deciding on past judgements [but for people to] tell me about their personal experiences of making disclosures in the public interest without me being able to do anything to resolve their individual cases [and] come forward [...] and share their views and experiences in order to help inform better practice in the future.”
4. However, Patients First would wish to emphasise that the ‘Thematic Review’ (on page 6, below) upon which this submission is substantially based highlighted serious concerns arising from both past and continuing cases. These concerns included:
 - the loss to the NHS of the services of highly skilled and experienced staff (either pending delayed resolution of their situation, or permanently) – some staff still being paid for a period of months or years, despite not working;
 - enduring patient safety concerns raised in past or continuing cases;
 - a significant number of otherwise respected health professionals (most of notable expertise and experience) being left destitute, marginalised and, in some cases, continuing to suffer from serious mental health conditions.
5. Furthermore, a significant theme identified was the failure of the law to protect those who had made protected disclosures about patient safety concerns.
6. Patients First continues to seek a wider enquiry or ADR process, for past and continuing cases, the resolution of which falls outside *The Freedom to Speak Up Review*.

PURPOSE & METHODOLOGY

7. As noted at point (1) in the Summary above, this submission is substantially evidence-based.
8. The facts of some of the cases are quite stark and distressing. Some of them have indicated that they would be prepared to speak to the Review about their experiences.
9. This submission is therefore intended to act as a gateway through which further information which might be helpful can be provided, without wishing to swamp the Review with 70 individual narratives (less still their support documents).
10. Many of those who took the time to answer did so quite fully but some responded much more briefly.
11. Not least because of having received rather more narratives from respondents than was initially anticipated (approximately double) it has not been possible to undertake anything like a forensic examination of each case. That said almost all the cases are known to an individual on the Team and we have sought to identify that pattern of particular characteristics across the cases as a whole.
12. It is hoped that with 70 individual cases collated and thematically reviewed, in the context of the combined experience of those on the Team working on this submission and the analysis of material in the public domain particularly in Annex 2 and 3, this submission presents a fair view of the overall picture. On any view, it does provide first hand examples of the diffuse concerns and experiences of whistleblowers, to which we have sought to give some structure.
13. Much has had to be left out of this submission but Patients First would welcome the opportunity to provide such further information as might be helpful, and perhaps help to identify a small number of individuals who could speak to specific points of interest to the Review.
14. A fuller description of the methodology used is set out in Annex 4 (on page 70).

SYSTEMIC ISSUES

Those who raise concerns

15. In the absence of much more positive, tangible and early support, whistleblowers are utterly exposed to the sort of, often shocking, treatment which the thematic review evidences.
16. Their stories are typically not heard (or not given a fair hearing) and their ability to garner evidence to support their position is seriously compromised by the measures taken against them by employers, including forbidding them to speak to other employees about the issue (e.g. while they investigate), excluding them from the workplace.
17. Furthermore, while the whistleblowers are isolated, the employer is often engaged in energetic attempts to 'manage', 'handle' or 'contain' the issue.
18. Those who raise concerns are extremely exposed and as noted elsewhere, belated and often inadequate protection offered by bringing a case in the Employment Tribunal ('ET') provides cold comfort, especially given the very stark inequality of arms (and financial resources) in such cases.¹
19. There is little or no evidence of a favourable sea change (see: the surveys in Annex 2, from page 45). Much of the evidence points to continuing shocking cases even if there is now a greater divergence between the best and the rest.

¹ Although the Public Accounts Committee was informed in March 2014 that money was available that could be used to provide financial support to cover the cost of legal advice for whistleblowers, the Team has not found any evidence of that having happened, ever.

12. If reprisals do occur, whistleblowers should reasonably be able to expect that their employer would provide them with the extra care and support that they need. ... Both HM Revenue & Customs and the Department of Health acknowledged that they did not have an earmarked budget to support whistleblowers, although both claimed that they had some resources which they could make available to cover costs such as legal advice.

<http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/593/59305.htm>

20. One year after the 2013 Francis Public Inquiry Report, the Nursing Times reported that nearly half of those nurses who have raised a concern about patient safety in the last year reported it had led to negative repercussions for them personally.

Source: Survey shows NHS is not there yet on raising concerns. Steve Ford Nursing Times 6 March 2014

21. Nearly half is a shocking proportion, especially if things are said to have drastically improved.

Those not raising concerns

22. The thematic review covered those who did raise concerns. By definition, it therefore excluded all those who did not raise concerns and who therefore never became 'whistleblowers'.

23. Patients First recognises that this is a material lacuna in the sources of evidence behind the thematic review – the importance of which is accentuated by the evidence (which did emerge from the thematic review) of people stopping raising concerns as well as anecdotal evidence from the Team.

24. By way of example of such anecdotal evidence, after one member of the Team wrote a letter to The Times in 2012 about the difficulties faced by whistleblowers², he immediately received a message from a professional acquaintance whose wife was an experienced nurse, explaining that:

"[my wife] is a specialist nurse in a hospital. She dare not attributably expose the shortcomings, unsafe practices, understaffing and waste which she comments on to me. If I speak to a journalist (she does not dare) I have to insist the tip-off is unattributable and cannot be traced."

25. The significance of this is amplified by the fact that the husband is successful and they are very financially secure. For those whose lives and livelihoods depend entirely on their own job (which might be imperilled by blowing the whistle), the fear must be of a quite different and greater magnitude.

² The Times, 25 Oct 2012

Duties & 'whistleblowing'

26. Health professionals are typically under duties to raise concerns;³ yet, this throws them directly into the danger of adverse reactions.
27. Against that background, the fact that there is even a term for 'whistleblowing' (let alone a need for legal protection of whistleblowers) denotes a systemic failure to ensure a culture in which health professionals can properly discharge their duties.
28. The ongoing and unresolved cases seen in conducting the thematic review for this submission, show that this systemic problem is both real and continuing, and has a bearing on what happens day to day.

Employers' approach

29. The approach of a number of NHS employers to the issue of whistleblowing is fundamentally flawed. It is addressed in detail in Annex 2 (on page 42) but stems from a definition of whistleblowing which *excludes* those who do so internally – the primary route for making protected disclosures under the legislation.

Disclosure of 'information' in the public interest

30. This remains an unnecessarily problematic area, with some court decisions seeking to define 'information' as involving only the conveying of facts (thereby distinguishing the early warnings of concerns and allegations). Not only is this a distinction without a difference (in the context of these provisions), but it is apt utterly to undermine the aims of the legislation, which include not only encouraging concerns to be raised but encouraging them to be raised early.
31. For the courts to have to resort to dressing up concerns as statements of fact that the employee holds such concerns is self-evidently scraping the barrel, to try to achieve a just result.

³ E.g NMC Code:

7. You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising.
32. You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.
33. You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.
34. You must report your concerns in writing if problems in the environment of care are putting people at risk.

32. The uncertainty here imports danger and risk to whistleblowers which is utterly counter-productive. Such uncertainty is itself unjustifiable as it seriously undermines the reality of the protection which the legislation is designed to confer.

Safety focus

33. Employers often focus their energies on the employment issue (rather than the patient safety issue). This is an inappropriate distraction. It happens too often (and in almost all of the cases reviewed by the Team for this Submission). A greater focus on safety and addressing the issue raised (rather than shooting the messenger) would appropriately re-focus attention on the primary issue of patient safety. A culture of addressing patient safety concerns would be likely to diminish the prevalence of recriminations.

Early recognition & intervention

34. The priority should be early protection and intervention: proactively to address patient safety concerns at the time and properly to protect those who speak up.
35. Early recognition of those who speak up as *whistleblowers* is important. All too often it does not happen. Whistleblowing policies are rarely applied to protect those who raise unwelcome concerns. Recognising the employee as a whistleblower is often viewed as a concession by the employer:
- as to the validity of any implicit criticism made of the employer;
 - which might impede action against the whistleblower; and
 - which is contrary to a case that the employer might later wish to run before the ET as to whether or not the whistleblowers actually made a protected disclosure.

36. The employer has every reason not to apply any of the policies which would afford the whistleblower protection. Without some effective counter-balancing factors, internal procedures are often worthless. Oversight by Regulators of how whistleblowers are treated and whether their concerns are addressed might provide some such counter-balance. Clarity as to whether or not the whistleblower was afforded recognition as a whistleblower at an early stage would also put down a marker as to the whistleblower's entitlement to protection under the relevant policy.

Paradox: serious and trivial issues

37. Paradoxically, the more serious the issue disclosed, the less effective the likely protection of the whistleblower:

- more serious issues are usually inherently more improbable – the whistleblower is therefore less likely to be believed;
- more serious issues are often seen as posing a greater threat to institutions and companies and, as a result, are more likely to generate a negative response, perhaps of denial, hostility or cover-up;
- more serious issues can require (or be dressed up as requiring) thorough investigations which are sometimes used to contain the information disclosed and to silence the whistleblower (see: Silence reigns, below);
- some Tribunals are very wary of damaging public institutions, such that they are unduly receptive to (almost any) alternative.

38. By contrast, a whistleblower disclosing a less serious issue is both far less likely to be treated with hostility and far less likely to fail before the ET, for a number of reasons.

39. This paradox cannot be consistent with the public policy objectives of the legislation.

Silence reigns

40. Many whistleblowers hope that by speaking out (usually to their employer) they will get misconduct out into the open and ensure that it is addressed. However, the opposite is often the case:

- confidentiality obligations are imposed during investigations;
- whistleblowers are often told not to speak to anyone about the allegations;
- ultimately, proceedings before ETs leave whistleblowers waiting for years sometimes before the issues are ventilated in court;
- meanwhile, documents which they would have been entitled to see if they were still at work are disclosed to them within the proceedings and are thereby subject to the implied undertaking not to disclose them to any other party; and
- mediation is sometimes abused – as a chance to apply improper pressure on the whistleblower, all under the veil of confidentiality of the process.

41. As noted above, not only do patient safety issues get side-lined by the employment issues, but even the employment issues get stalled and contained⁴.

⁴ E.g. From the thematic review of narratives: *“Had the concerns (I) raised were addressed expediently by the Trust’s Senior Management and had the former Medical Director not disregarded the [Royal College] invited service review report (of 20XX) such prolongation of illness and disability (+ handicap) in a large cohort of patients would not have occurred. (Knowingly) Causing distress and disability is harm. The “significance of harm” (done) is not for doctors / specialists to determine. It’s for the patients, their families and the advocates to know and determine.*

“By the exclusions imposed on me by my ‘case manager’ (Deputy Medical Director), not specifically preventing me from disclosing the case outside the Trust, but with an implied threat that my employment would be terminated if I do so I have so far been hindered from acting in the best interest of patients (ie:- ensuring that there is duty of candour)”

Blacklisting in ESR

42. Another systemic issue is the informal, but very effective, blacklisting of staff apparently assisted by use of the electronic staff records (ESR), a hidden part of staff records. Whilst whistleblowers' reports of repeatedly not being selected for interview or offered a job may be indicative, they fall short of being probative. However, pulled interviews and job offers (i.e. interviews offered or job offers made, which are subsequently withdrawn without explanation) would appear to have more probative force and provide a more sound basis for a concern⁵ that some informal blacklisting is happening to whistleblowers.

Maintaining High Professional Standards

43. This is another systemic issue giving rise to serious concerns and mistrust. Maintaining High Professional Standards (known as MHPS) is often used as policy instrument to quite different effect, particularly against whistleblowers.
44. It is a policy ratified by the BMA, which according to anecdotal reports from a senior barrister (outside the team) who is familiar with such cases, makes life very difficult for doctors, as it allows a Trust, in effect, to set up its own kangaroo court and, despite this possibly leading to termination of a doctors contract, legal advice and support in meetings are frequently not permitted. This effectively circumvents all the protections which might otherwise apply in any other process or procedure.
45. This policy has been used in several examples against doctors. For example, it was used against one doctor, supposedly for misconducting herself in a mediation. The Trust was attempting to use MHPS to set up an investigation into the failed mediation, but the investigation was all into her conduct, notwithstanding: (a) conduct by the Trust in the mediation, which might be regarded in many quarters as surprising, to say the least; and (b) the doctor's exemplary conduct in response to that.

⁵ Patients First's awareness of this concern arose prior to the thematic review; see also, e.g.

"Obviously I have suffered income, career + pension losses. [...] will lose my home. Only 1 job offer which was withdrawn." [emphasis added]

'Independent' investigations

46. The use of what purport to be independent investigators and the use of the material which they provide is a common process step frequently giving rise to serious concerns.
47. If investigators are not properly independent, the problems that arise are self-evident.
48. However, even if the investigator begins from an independent standpoint, the employer's opportunity to provide 'context' in the absence of the whistleblower often affords the employer a chance to skew the approach to the investigation as well as to drive its process, without any materially equivalent input from the whistleblower.
49. Even if the investigator remains wholly independent, the concerns do not end there, since it is then for the employer (who typically receives the report first, or sometimes even in draft) to decide how to use it.
50. The now well-known editing of the Sibert Report in the Baby P case provides a striking example of how a report can be used or misused. In that case, the report by Professor Jo Sibert said the doctor (Dr Al-Zayyat, who was was not on the specialist register and had been appointed by Great Ormond Street with only limited experience of and training in child protection) should have admitted Peter to hospital for tests and alerted his social worker because he was on the child protection register.
51. However, Professor Sibert also criticised serious problems at the clinic, where there was a lack of staff and poor case management, doctors having few medical notes on the children they were examining. But these aspects of this report were omitted from the second serious case review, the official account of the agencies' failings over Baby P.
52. Most whistleblowers are marginalised or discredited if they seek to challenge what purports to be an independent investigation, even where it has apparent flaws. Few have the means to pursue such issues to expose the truth and seek (let alone achieve) fair dealing on the patient safety concerns raised.

THEMATIC REVIEW

Introduction

53. The respondents included doctors, nurses, a Board member, Professors, an ex HR director and other health professionals, mostly clearly very experienced and competent in their field: the Team formed a fairly strong impression that the expertise and experience of the respondents tended to be well above average in their field, which mirrored other anecdotal information (as already noted above).
54. The results from 70 respondents (of whom around one fifth had taken their case to an ET or court, all the way to judgment) showed that:
- 73% were cases which appeared to be well documented
 - 14% were cases which were (relatively) less well documented
 - 23% were cases in Scotland
 - 47% were cases which were ongoing and unresolved
 - 13% were cases in which a compromise agreement including a confidentiality clause had been signed
 - 57% were cases in which a regulator (e.g. the CQC) had been involved
 - 19% were cases in which there was an unusual or decisive legal issue
 - 79% were cases in which bullying had occurred
 - 100% were cases in which the whistleblower suffered detriment
 - 20% were unable to access legal advice or simply ran out of money
 - 40% were let down or unsupported by the relevant union (e.g. BMA)
 - 60% were cases in which there was waste of talent, money and resource by forcing out the whistleblower or keeping them on suspension or special leave
 - 43% of respondents are no longer working in the NHS
 - 1% reflects only two respondents (out of 70) who secured interim relief from the ET under s.128 era 1996

55. In addition, a number of themes emerged from the narratives and from specific observations (albeit that some specific observations cited are much easier to construe in their full context).
56. Some of the narratives were quite harrowing, including accounts of the effects on whistleblowers and their families. The narratives presented quite a diffuse picture, from which the Team has sought to provide some illustrative observations for each theme. Although the themes emerged overall quite clearly, some observations overlap with other themes. Nonetheless, it is hoped that the examples given will be helpful, even without their context.

Initial disclosure of patient safety concerns

Understaffing - vulnerable patients

57. Concern regarding the understaffing of the NHS in locations with high numbers of vulnerable patients and a failure to respond in a timely fashion when concerns were raised is a recurrent theme amongst the Patients First members whose stories were collated for the purposes of this Review.

EXAMPLES

- [QQ]: Concerns raised over low staff for school for children with special needs and operating theatres. Concerned that when [QQ] worked as a HCA in a school for children with special needs - 75 children based on each school site (Primary and Secondary). HCA only point of contact was occupational therapist, who only worked on site for half a day per week. HCA often left as the only medical staff on site.
- [WW]: “My assistance in the operating theatres was withdrawn, leaving me operating on major cases alone. I had to call the on-call registrar on 2 occasions in order to complete the procedures.”

Dismissive attitude to disclosures

58. Disclosures were often met with a dismissive attitude. Once senior staff realised what was going on, whistleblowers were often prevented from collating evidence to support their case.

EXAMPLES

- [GB]: ‘Although the Trust’s Senior Managers ‘claimed to be’ concerned, we felt they saw us as or gave the impression that ‘we were an annoyance to them’. The Medical Director Prof MR in particular was menacing towards us, rather than being supportive of us of our concerns. Prof MR clearly indicated how the ENT Directorate was run “was not his concern” and who was rewarded financially or otherwise “did not concern him”, and was entirely up to the “Directorate”.’
- [XX]: ‘Obstruction at every stage of the audit which highlighted patient safety concerns ... Director of governance sent divisional manager to intimidate me and confiscate all the audit data I had ... Divisional manager blocked my access to the data base preventing me from completing the audit which revealed the missed cancers.’
- [UU]: ‘NHS banned me from my emails which housed all my evidence of concerns raised.’

Lack of clarity & confidence

59. Staff unclear whether they are simply *raising patients’ concerns* or are ‘whistleblowers’. In some cases, individuals do not consider themselves ‘whistleblowers’. Individuals seem unclear what constitutes “Whistleblowing”. (The fact that NHS employers apparently adopt an unhelpful and apparently flawed definition of whistleblower is unhelpful – see: Annex 2, on page 42). Clarity is necessary prerequisite to there being proper practical protection for whistleblowers raising concerns and for them to have confidence in any such protection.

EXAMPLES

- [RX]: distinguishes himself from “...whistleblowers who worked in provider and clinical settings directly.” RX worked for a PCT.
- [SS]: explains at the time concerns were raised, [SS] did not consider themselves a “Whistleblower” nor expect to be one.

60. Few aware of Whistleblowing policy/Whistleblowing policy inadequate:

EXAMPLES

- When [SS] realised they were whistleblowing, found the policy with great difficulty. It was “hidden” in the code of staff conduct. [SS] followed the policy, did not set out to be a whistleblower... “became one by default.”
- [ZZ]: was aware of employer’s whistleblowing policy, but “nothing more than a piece of paper.”

- Common lack of legal knowledge on the part of whistleblowers at the outset of the case. Many whistleblower would “do things differently” as a result e.g. remain anonymous or leave first and then blow the whistle.

61. Whistleblowers misled/misinformed by employer about policies:

EXAMPLES

- [RR]: realised at Tribunal level that Trust policy states that an employee does not have to have supervision with their direct line manager. RR did not feel that there was any effort on the Trust’s part to accommodate RR in respect of supervision.

62. Whistleblowing policy simply not applied:

EXAMPLES

- [OO]: Despite ET finding protected disclosures made in good faith, whistleblower was never regarded as a whistleblower and no whistleblower policy was invoked – she was afforded no protection to which she was entitled under two relevant policies.

Barriers encountered – bullying and unfair process

Issue transformed to become an employment issue

63. A common theme throughout the stories collated was the tendency for patient safety concerns to be ignored or recast as individual employment issues:

EXAMPLES

- [XX]: ‘Tried to make it as an employment issue as I had raised clinical concerns and bullying / harassment in the unit.’
- [SS]: “the concern I have raised about unsafe practice...is still to be heard and the culture which stifles concerns and takes punitive action against those who raise them” remains. [SS] raised a formal whistleblowing complaint with the Vice Chair of the NHS organisation, however, director of HR advised that concerns raised were an individual ‘employment issue’ rather than an issue of patient safety.
- [RR]: In specific email exchange between [RR] and Director of Human Resources, Director said “you have now asked the organisation to champion your cause and that is what I intend happens in what I hope will be a speedy, focused, yet elemental manner.” During an ‘External Investigator Review’ [RR] raises their concerns with use of the phrase ‘champion your cause’ and

emphasises they raised concerns in the interests of public, not in their own interest.

- [AB]: investigation was delegated by the head of HR and discussions of AB's 'redeployment' were made.

Review Process

64. Reviews were often said to be dealing with the patient concerns, but lacked integrity and did not intend to resolve the issues so much as push them under the carpet. It made little difference whether they were carried out externally or internally; in both scenarios, it was possible to engineer findings to evidence a premeditated outcome.

EXAMPLES

- [GB]: 'When reports from external reviewers did not agree with the Trust views they were hidden or in some instances the external reviewers were challenged. More reports (and reviewers were called for) The Royal College External review panel was challenged by Prof MR. Altogether 6 reports were commissioned and called at a considerable expense. At present the Trust's Senior Management is complacent that they have "proved there was no harm".'
- [IB]: '...The external investigator was one who was already being employed as a paid expert witness in the negligence case for AHCH which he was now reviewing as an 'independent reviewer' - a clear conflict of interest [as] he was not able to provide a fully independent review.'
- [PB]: 'I specifically requested an independent investigation into the apparently corrupt practice of using biased 'reviews' to suppress the concerns of whistleblowers ... consultants undertake a superficial or biased 'review' of the situation and conveniently find 'no evidence' to support the complaint. These exercises are subsequently claimed to have been a "complete investigation".'

65. Bureaucratic processes when whistleblowers' concerns raised - process of attempting to address concerns raised by Whistleblowers seems to be long and bureaucratic. i.e. member of staff raises a concern, it is passed on to another member of staff via email, demonstrating that concerns are dealt with superficially, leaving underlying patient safety issues not fully addressed.

EXAMPLES

- [RR]: pointed out that there was no resuscitation equipment for Pulmonary classes, requested it be discussed as a team, line manager 'emails' Physio - responsible for classes...little done then on.
- [QQ]: "I raised concerns with the school nurse and line manager about the stress...on me and the danger..." re: losing members of staff "...could put the

children in.” “I was assured that we would have a new nurse post soon. This took 7 months.”

- [WW]: an abusive email from Northumbria CD – sent to colleagues (original version all in capitals) – stating ‘X needs a rocket up his arse, all this work will be done in Northumbria, not Carlisle / newcastle, who’s going to tell X?’

66. Few members offered or received mediation. Despite requests, mediation rarely used.

EXAMPLES

- [NN]: stated that even though they agreed to mediation, their line manager refused.
- [DD]: “My Work place Union rep asked for this repeatedly in the informal stage. It was initially agreed by myself, but was never implemented by management. It was never suggested in the formal stages. Most requests or questions put forward were met with a ‘wall of silence’”

67. There seem to be relatively few attempts at mediation (7 out of 26) [in one section of the review] and there are clear cases where it is not felt to be a helpful or constructive process, but increases stress and puts the whistleblower under intense pressure. None of the mediations referred to resolved the patient safety issues. In some cases there seemed to be a misunderstanding as to what an independent mediation is or should be, or perhaps a lack of clarity about the rules which apply and the purpose of the mediation.

EXAMPLES

- “A mediation meeting...regarding my exclusion...but this did not help to resolve my issue, rather Trust used it to get rid of me and make my situation even worse.”
- [LC]: “a Mediation Agreement was drawn up. The Trust broke that agreement and I continued to be subject to distress. A further mediation was held but management simply used that mediation to present me with an ultimatum - accept an exit package or be sacked.”
- [IB]: “I attended a ‘mediation’ with my employers with their own appointed ‘mediators’ NCAS despite my objections that NCAS were neither independent having advised only the trust in the past and being an employer resource. Patient safety issues were discussed but the patient safety issues instead of being resolved became more critical (hospital became more unsafe).”
- [FF] “I attended a meeting at ACAS with NHS management. Not at all helpful and did not resolve any patient safety issues.”

- [RM] “Independent mediator appointed by employer. Extremely intimidating experience and gave those who I had raised concerns about opportunity to humiliate me collectively. no mediation offered by mediator.....and told ‘had engaged in process, hadn’t worked and we don’t want you back’”.....“Felt totally humiliated during mediation meeting....felt it gave those who I had raised concerns about one final opportunity to humiliate me collectively. Found experience extremely intimidating.”
68. There appears to be an absence of clear and widespread efforts to mediate or actively resolve the conflict. The quotations above suggest (1) mediation can be actively used by management as an opportunity to bully the whistleblower; (2) there can be an absence of genuine attempts to mediate on the part of management and in some cases a refusal to mediate even though the whistleblower is willing to do so; (3) there is a mistrust of the “employer’s” mediation-provider who is not seen as independent, even though this may sometimes be unfounded; (4) in many of the cases reviewed, there is little mention at all of the mediation being a helpful or positive experience, which suggests that, as currently used, it is currently of very limited value – in fairly stark contrast to the statistics of user satisfaction in other contexts.
69. Mediation cannot be used to address bullying within an organisation unless the bullies acknowledge their behaviour. The more endemic the bullying is (e.g. if HR is party to or orchestrating the bullying), the less the accountability or sanctions which are ever likely to be imposed upon the bullies, however bad their conduct towards the whistleblower.
70. Mediation should be part of an early intervention process. Not late. David Lewis has already written about how mediation attempted before an ET hearing is late in the process and employment orientated (not patient-safety orientated) so the parties are entrenched; in such circumstances it has limited prospects of success. It seems likely that a specially designed ADR process would be better suited to resolving whistleblowing disputes.
71. Mediation needs to follow good practice. Some of these cases show that: (i) there is a real or perceived lack of independence and neutrality, which undermines the mediation - creating a lack of trust in the process; (ii) a mediation can be used by management as another attempt, under the guise of a dispute resolution procedure, to bully the whistleblower and a weak mediator may not deal with this effectively.

EXAMPLE

- “There was a mediation which I wouldn’t say was independent; it was a very difficult protracted process, that was in effect a stitch up or attempted stitch up before it started.”

72. The Patients First proposed early intervention proposal is NOT simply confined to a form of mediation - its focus is on the patient safety issue raised. Complementary tailored mediation or ADR might well provide an additional process which could be used if necessary.
73. Informal/ unrecorded meetings (often with no prior information or agreed agenda and sometimes without anyone accompanying the whistleblower):

EXAMPLES

- [SS]: raised concerns and the response was bullying and intimidation, especially in meetings, where no minutes were taken.

Creation/allegations of misconduct

74. A common trend was for the Trust to find evidence of misconduct that could then be framed as misconduct and grounds for suspension, disciplinary action and/or dismissal.
75. This was done in two ways. Firstly, to make it extremely difficult for the person to fulfill their duties at work by changing their working conditions (e.g. conflicting obligations from overlapping times on different rotas that could not possibly be fulfilled). The second was to unearth historic misconduct, dating back years and previously never raised, which purported to be the grounds of suspension and/or dismissal.

EXAMPLES

- [FB]: 'I was refused a printer and adequate equipment to work in my when I had disability problems.'
- [LC]: 'Management made life very difficult for me by freezing posts or freezing budgets in my department, such that I had to work extra hours and during my annual leave, and also spend my own money on the needs of my department.'
- [QB]: 'In addition to passing my clinical concerns up to the TMD my manager (PJC) now began a slow campaign of bullying me. He ensured that when we replaced the short-term locum we appointed another breast surgeon not a substantive GI surgeon ... This ensured I, and my senior colleague, and the long-term locum, CEK, (who by now was substantive) were left for four years to carry the burden of performing all of the major operating within the Trust. I audited activity at this time and three of us were performing 75% of the laparotomies across the Wakefield site. Personally I was busiest emergency surgeon in the Trust for five years.'
- [YY]: 'I was also given a timetable, which was inaccurate, which again later led to accusations of non-attendance even though I informed my clinical director of the

timetable inaccuracies ... There was also no admin support whatsoever and I had to produce my own clinic letters and book my own appointments.'

- [UB]: 'I was suspended three months after, September/October 06, four months later I was handed six years' worth of allegations I knew nothing about, that I had to answer to ... NHS Lothian sacked me two and half years later following an investigation into my alleged gross misconduct. This rendered me unemployed for the first time since I was sixteen years old.'
- 'I got suspended from my work three weeks later, on 12th February 2014 on the basis of a clinical case, which was seven months old and no harm had come to the patient. Medical director cited unsubstantiated and a baseless whistle blowing case as one of the reasons for exclusion. I have been referred to GMC as well.'

76. Fabrication of Evidence/Unsubstantiated allegations as retaliation/employer strategies to victimise/blocking disclosure of important information, reports etc.

EXAMPLES

- Dishonest behaviour and lack of integrity occurs at all levels without regard to rank or job. [DD]: The approach is often to "turn...concerns and recommendations into my capability issues and start to use unacceptable behaviour and work load."
- Management/HR tampering with evidence and fabricating allegations is a common approach. [LL]: "I ... gave the NMC my response to the allegations being made against me. I paginated every inconsistent statement given by my colleagues over the two and a half years of meetings. Evidence where off duty had been changed. Things written by colleagues that weren't on duty at the time etc: A line that HR had included in brackets in one of the statements that stated: '(get the dates to match the incidents)' which was brought up by the Tribunal as well, but clearly ignored by the panel. I was very surprised that the NMC did not approach any of my colleagues given that they very obviously lied, but apparently it's me that has to do the referring."
- [II]: "Allegation of physical abuse of a patient, where after a flawed investigation dismissed me for gross misconduct,...I was before a magistrate on 28 May 2012, where the judge dismissed the case and acquitted me."
- [EE]: "The patient then killed herself about a month and a half later. The notes then disappeared.....they started on a new trumped up charge and even started to lye about events...in order to make it look as if my ability to risk assess was at fault".

77. Some cases show that management go to considerable lengths to conceal information from the whistleblower especially where that might incriminate management or be otherwise useful to the whistleblower's case. Evidence is destroyed and information is frequently covered up and kept from the whistleblower.

EXAMPLES

- In the case of [BB:] "I find my statement has been highly 'edited', removing all context to risk to other clients. This version has been sent to CQC, NMC and ISA.....I will be questioning [at forthcoming ET hearing] if the 'editing' of my statements represent an endeavour to mislead the NMC, and others, and brings the profession into disrepute. (Forgery)?" [BB].
- [LL]: "I was suspended...four months later I was handed 6 years of allegations I knew nothing about...regularly have statements put through my door with more allegations telling me what an awful individual I was."

Bullying Behaviour/Management not held Accountable for Bullying Behaviour

78. Bullying is an almost universal feature of these cases (clearly apparent in 56 out of 59 cases [in one section of the review] ie 95%) and the nature and extent of it can be illustrated by the following examples:

EXAMPLES

- [TT]: "Then the horrendous bullying started which involved being sworn at, shouted at, threatened, banging his head on the table, putting his face up to mine and slapping his head."
- [MM]: "I raised [concerns] with my line manager and their line manager. Their response was bullying and intimidation particularly in un-minuted meetings."
- [JJ]: "Ward Manager - Bully. Traumatized me so badly causing Anxiety adjustment disorder/Post traumatic stress disorder....."the most dreadful experience of my life....horrendous....horrendous for my family....my life has been wrecked."
- [FF] : "I was bullied relentlessly throughout meetings lasting three hours at a time. Following these meetings false allegations were made against me with union rep who attended refusing to act as witness.....further harrassed to attend meetings without representation once union rep had gone."
- [EE]: "One of the managers would 'shush' us by putting her hand up to stop you from speaking....one of the patients [the manager] bullied came to me for help. When I complained and he found out he also bullied me.....the patient then killed herself.."

- [GG]: “Consultant Paediatrician subjected me to humiliation...only later did I understand that a vendetta had been orchestrated by my clinical nurse manager.”

79. Intimidation/bullying experienced by ‘whistleblowers’ even outside of work in their private lives/own homes.

EXAMPLES

- [AA]: “One of the three of us received a threatening phone call at her home promising to burn her house down if she did not stop pursuing her concerns.”
- [WW]: When raised concerns, phoned by the MD at home on a Saturday and threatened that if they came into work, or attended their visits, their practice would be investigated and it would be “unpleasant.”
- [FB]: describes bullying and harassment experienced at work, and even “bullied and harassed” on own residence and “terrorised kids”

80. In only one case in one cohort of 20 respondents was any employer individual punished or held accountable for bullying behaviour or making or framing unfair or unfounded allegations.

EXAMPLES

- In the [TT] case the manager “was subsequently sacked only after we whistleblew”.

81. Many stories recorded a culture of fear with staff afraid to raise patient safety concerns or support their “whistleblowing” colleagues for fear of losing their jobs or being badly treated in the workplace.

EXAMPLES

- [RR]: raised concerns with colleagues following discussions on Pulmonary rehab classes, however, colleagues unsupportive. RR suggests that this was due to the negative treatment she received as a “whistleblower.” They feared the same would happen to them.
- [QQ]: in this case, colleagues and staff members initially realised the pressure “whistleblower” was under. However, when “whistleblower” lost job and appealed, colleagues were unsupportive and feared they would lose their own jobs.
- [FE]: “Many staff told me they were afraid to speak out.”
- [VV]: explains that colleagues only discussed wrongdoings “*off the record*” and as soon as VV raised more concerns in writing, was avoided by colleagues.

- [ZZ]: staff too frightened to raise patient concerns “for fear of what would happen”; “those who did raise them were bullied out of the trust.”
- [CB]: “significant potential witnesses are too afraid to speak out or have signed confidentiality agreements or, in some cases, were themselves caught up in the cronyism and rewards culture and are now ashamed of their part.”

Suspension/dismissal

82. This was often done in a public and humiliating manner, with the phrase ‘escorted off the premises’ coming up regularly.

EXAMPLES

- KB: ‘I was escorted out of the building and suspended; taking with me copy evidence and correspondence relating to my whistleblowing. I was subsequently dismissed despite no evidence of any wrongdoing.’

Lack of support/representation

83. Union Conflicts of interest and failure to support the whistleblower. In a number of cases, the union withdrew legal representation at the last minute and left the whistleblower unsupported and in an extremely unsatisfactory position.

EXAMPLES

- [NN]: the support was withdrawn on the basis of information received of which the whistleblower was wholly unaware and did not have the chance to refute: “The RCN provided a lawyer...then 48 hours before the [ET] hearing the RCN withdrew the lawyer (provided 7 months earlier)...the lawyer handed over the correspondence to me which included the full independent investigation report (suppressed for 11 months). The correspondence also contained a 12 page precognition statement by the RCN officer...the content falsely painted me as a troublemaker and this had never been discussed with me.”
84. Unions frequently conflicted either (1) in close cooperation/collusion with management, or (2) advising other members involved in the dispute with the whistleblower.
- [AA]: “Local representative out of her depth. She tried desperately to get senior help from regional office to no avail...interview was a waste of time...they were also supporting the individual who we raised concerns on...I withdrew from the RCN”

- [NN]: “RCN Professional officer...claimed to be supportive but I later discovered she was in collusion with management and human resources department.”
- [BB]: “RCN on the advice of their external legal advisers withdrew their support for Employment Tribunal....I think on grounds of evidence ‘edited’ by [employer]”
- [LL] “I had to go outwith RCN and Unison as they were supporting my colleagues and I had no faith.”

85. Very mixed performance by Union officials - some good, many poor.

EXAMPLES

- [DD]: In one case, Unite Scotland: “VERY supportive and all decisions and way forward mine after discussions.”
- [JJ]: “RCN Edinburgh very supportive”
- [MM]: “Sympathetic, understanding and supportive”

86. On the whole the cases suggest that support was slightly underwhelming, generally somewhere between “better than nothing” and “just about ok”:

EXAMPLES

- [EE]: “Neither RCN nor Unison were much help. Processes dragged on for years unresolved. The union is also not sure whether it can support me in a constructive dismissal unfair dismissal claim....these are hard to win and the union may not want to risk wasting legal fees on my case.”
- [FF]: “Unison Rep refused to support me as I attempted to have patient care issues addressed - he told me if I didn’t agree to move to another area to work (as I was being pressurised to do by my management) he was no longer interested in supporting me. I was then left without representation.....unable to join another union for 6 months.”
- See the quote above in the [NN] case “48 hours before the ET hearing the RCN withdrew the lawyer...” and “the three letters ...confirm that the RCN let me down.”
- [PP]: “I was advised by the RCN officer not to approach a regulator...as it was a long drawn out and destructive process”.

87. In a few cases where staff changed Unions this seemed problematic, leaving the whistleblower without union support until after 6 months has expired i.e. qualifying membership of the new union.

88. Reports commissioned from various bodies (e.g. RCN, GMC) were often not conclusive. Even if they uncover malpractice by the employer they do not appear to be acted upon.
89. It is often difficult for the whistleblower to force disclosure of information held by the employer until legal process requires disclosure e.g. ET or Court proceedings.

EXAMPLES

- [AA]: “Despite our attempts to get this report, NHS Manchester refused. It was only an order by the judge in our court case that allowed us to view the report.”

Lack of leadership/Board conduct/Role of NEDs/Response from Umbrella bodies e.g. NHS England.

90. Attempts to raise a serious issues to a higher level will generally prove extremely difficult. There appears a clear strategy of closing ranks and putting the whistleblower under sometimes enormous pressure to leave or accept a compromise agreement. So whilst there are cases that become so difficult that they rise to the board level, many whistleblowers appear to have to battle with middle managers and HR executives who are bullying the whistleblower and doing their best to prevent the dispute from escalating.
91. There was limited information about board level reactions to whistleblower cases or that the board in any way intervened as a voice independent of HR or direct line management. There were no examples of NEDs having a positive or important independent role to play. Non-executive directors are usually apparently no more helpful than any other board level member.

EXAMPLES

- In the AA case there appeared to be many difficulties at a higher level [AA]: “Despite attempts to get this report, NHS Manchester refused”....”Trust Board members tried to insist on drawing up the terms of reference for the Whistleblowing investigation...refused outright by [the investigator]”...”the associate director for Corporate Affairs tried to get us as much support as he could, however the Board and HR ignored his concerns”. The paper from AA includes reference to much evidence against senior managers and the board at NHS Manchester. “I raised my concerns with head of department and Regional Director...all managers closed ranks to shut down the issue.”
- [MM]: “The core concerns around child safety have still not been addressed.....I find this a very serious concern indeed. Is it deliberate avoidance at Scottish Government level or simply lack of understanding?”

Legal Issues/lack of legal representation

92. Often whistleblowers have no idea that they are 'blowing the whistle'; they just think they are doing their job properly. Most respondents in the thematic review had no idea that they were blowing the whistle in the legal sense or that they were stepping into complex legal territory. However, many said they would be much more careful if they ever had to blow the whistle again and, if they did, many would do it differently.
93. It is universally clear that there is no level playing field between NHS employers and whistleblowers in terms of access to legal advice. Not only is this crushing for the whistleblower and extremely intimidating, but there were cases where: (i) the whistleblower's lawyer probably didn't understand the complexity of the issues at play; (ii) the Union lawyer withdrew at the last minute; and (iii) in one high profile case, the lawyer turned on him in an attempt to recover substantial legal costs.
94. There were no cases apart from those which have made the law reports/had an impact on the law where an unusual legal issue was central to the case. On the whole the cases were not in fact about legal issues, they were about the breakdown in human relationships and the inability to repair them.

Detriment suffered

95. A strong theme throughout all stories was the impact felt by whistleblowers on their professional, personal and financial wellbeing.
96. The evidence of detriment is overwhelming and was clear in every case examined. The spreadsheet was populated with an affirmative in every single case. Typically, detriment was suffered in both personal and career terms: chronic and sustained stress; anxiety, often severe, over a sustained period, frequently leading to isolation and depression; isolation, victimisation and bullying were almost universal (almost all cases), leading to breakdowns and the inability to cope and work; the adverse effect on marriages, children and families was widespread, with children suffering depression and divorces occurring; in very many cases careers were in effect ruined (suggesting "once a whistleblower, always a troublemaker"), so the prospect of not returning to work a real one for many whistleblowers; so typically a whistleblower will be financially far worse off, with lower income, legal costs they cannot afford, losing their homes in some cases, losing pension rights, plus the inability to obtain work. This leaves many whistleblowers on benefits or scraping a living in any way they can, relying on a partner's earnings often whilst having a young family.

Professional

97. Many felt de-skilled and that the Trust's treatment had damaged their reputation. Others felt they would never be able to face working in the NHS again.

EXAMPLES

- [HB]: 'My specialist training which had been progressing uninterrupted and excellently has not come to a premature pause. I have lost a year of my training and possibly more due to the ongoing unjustified GMC investigation.'
- [LC]: 'Getting a job with the stigma of dismissal, especially when you are in the newspapers, is essentially impossible. If you can find one, you have to accept a temporary locum post, usually at a lower grade. I have had to give up any idea of retiring, and I now have no choice but to work as long as I am physically able in order to make two ends meet ...'
- [SS]: 'This statement was written two years ago. I have now been blacklisted for around 20 jobs at my grade and continue to suffer severe financial detriment and pension loss.'
- [YY]: 'I have been unemployed since being made redundant. I doubt that I will work as a doctor again. The smear against me is such that it would be very difficult to start again, and I do not think I could cope with the level of fear and anxiety that I believe future medical employment would entail. I have become less resilient. I could not live through more allegations and victimisation.'
- [RR]: isolated; unemployed but not in receipt of "unemployment benefits" due to NHS blacklisting
- [SS]: illegally suspended and disciplined without investigation. Disciplinary action taken against SS without following normal procedures. Found guilty of gross misconduct and salary downgraded.

Personal

98. Psychological and physical damage to health was commonplace, often compounded by the whistleblower then being investigated by the GMC in fitness to practice proceedings. Such stress also impacted on the families of whistleblowers, not to mention their patients and colleagues, and was particularly acute where the individual was single/sole wage earner.

EXAMPLES

- [FB]: 'reported to GMC by medical director because of deterioration in health due to multiple emotional trauma.'...'I am a single parent of two small children with no friend and family support in this remote area.'

- [HB]: ‘My marriage temporarily broke down due to the severe effects of trauma on my husband who now needs psychological care.’
 - [ZZ]: in debt, fear of housing repossession, diagnosed with PTSD.
 - [DD]: “Isolated, lonely and frightened for the future....unfit mentally and emotionally to return to work till recently...daughter became very introverted and worried leaving my side 13-15 years, suffering migraines and generally depressed herself”
 - [JJ]: “The most dreadful experience in my life....it haunts me every day and never can I wake up in the morning and find the nightmare is over....eroded my mental health and energy, to the low point it is today where I am running on empty.”
 - [MM]: “I am personally devastated by how I have been treated. I feel that I have been savaged by a mob of wild dogs who are still baying for blood around me and these are the most senior managers in my organisation.”
99. There was evidence too of the effect on family members, as well as direct and indirect references to that effect being used as a lever of persuasion against the whistleblower.

Financial

100. Suspension with reduced pay, and crippling legal costs, left many financially destitute. Interim relief is a rare gift. It was received by a mere 2/70 stories (AA, KB) – this equates to less than 3%, but was not sufficient to insulate the individuals from subsequent financial loss.
101. Those kept on long-term suspension often criticised the waste of NHS resources. Nonetheless, the final quotation represents why none of the stories studied accepted a compromise agreement or pay-off; money is never what whistleblowing is about.

EXAMPLES

- [OB]: ‘My personal loss in legal cost is £80,000, which I have raised through re-mortgaging my family home in rural Ayrshire.’
- [NB]: ‘Suspended and my pay is reduced every month by about £100 pounds.’
- [GB]: ‘I still draw a full consultant salary on a “monthly basis to stay at home”.’
- [LC]: ‘Even though I provided scores of letters of appreciation from patients and from colleagues, and even though my junior staff wrote an impassioned letter pleading for me to be kept in my post, little did I realise that if an NHS employer is determined to get rid of you, they will find a legal way of doing it, or the financial pressures will be such that you will give up on any legal fight.’

Patients First

- [YY]: 'No financial compensation is adequate in the aftermath of severe victimization. I would rather it had not happened. Compensation would also not address my unresolved, original concerns. The current situation fails both the public and staff.'
- [FB]: facing eviction/homelessness.

ANNEX 1: FULL RECOMMENDATIONS

1. The workplace environment that best enables and supports patient safety is now well established. It is one with a “just” culture, an understanding of human factors, rooted in high levels of staff engagement, and appropriately resourced, led and managed.
2. Such an environment is incompatible with a culture in which bullying is significant and tolerated, as this hinders learning, undermines staff engagement, and is likely to lead to those raising concerns being ignored or being seen as the problem, rather than the concern they are raising. That, in turn, is likely to deter other staff raising concerns.
3. Notwithstanding the extensive publicity, soul searching and political initiatives that followed the two Mid Staffordshire NHS Foundation Trust Inquiry Reports of 2010 and 2013, survey data from all sources suggests that progress since 2010 on creating such an environment is at best patchy and certainly does not yet demonstrate the step change in culture it was hoped those two reports would help promote.
4. The organisations – employers, professional bodies, regulators and trade unions – from whom staff who wish to raise concerns should be able to get support have, in different ways, not yet met the challenge. This is particularly important in respect of NHS employers where there appears to be a growing gap between the better employers and the rest. The latter appear to over-estimate the importance of policies and underestimate the importance of changing culture.
5. As a result the proportion of staff who fear raising concerns or who do nothing after their concerns are ignored remains alarmingly high. Policy measures to address this are not assisted by an over-optimistic view of progress and real confusion about what “whistleblowing” means.
6. Our recommendations focus on specific practical steps but we are in no doubt that unless the Francis Review also addresses the wider issue of bullying, it will not be able to decisively improve the culture within the NHS towards a “just” culture in which raising concerns is expected and welcomed.
7. The recommendations which Patients First invites the *Freedom to Speak Up Review* to consider are as set out below.

Public Inquiry

- (1) The Secretary of State to initiate a Public Inquiry into patient safety and the treatment of those who raise or have raised concerns, and who suffer material detriment. Such Inquiry to consider both current and historic cases with a view to fostering a radical culture change within the NHS and allow closure, making some provision for redress in appropriate cases.

Bullying

- (2) The Secretary of state to launch, with NHS England and all three NHS regulators a major initiative, to be agreed with trade unions, on adopting zero tolerance for bullying within the NHS, using the US Joint Commission Standard as its template.
- (3) Each Trust to draft a positive list of required behaviours (at all levels in the Trust, including HR and management) regarding openness, transparency and the prevention of bullying. These behaviours should be “always events”, rather than simply what might trigger disciplinary action. All managers to undertake fresh training in understanding what amounts to bullying behaviour and how best to avoid it and manage its prevention – in particular in relation to staff and patients raising concerns – to instil confidence in all staff to deal with bullying confidently, in a measured way, but assertively.
- (4) It should be Board priority, using independent staff survey data, to explicitly identify areas in which there are indicators of workplace bullying, negative behaviours, or heightened work stress, so as then to focus efforts to create a positive organisational culture in which appropriate support is provided and bullying and negative behaviours are appropriately challenged – and positive behaviours acknowledged and endorsed.
- (5) Formal policies and procedures should be promoted to outline the organisation’s explicit commitment to tackling bullying. This should underpin and be directly linked to effective training to prevent and manage bullying. Training should be delivered to a critical mass of appropriate staff (particularly managers) to avoid being ineffectual and to develop trainee insight into their own behaviour and its impact on others and developing interpersonal communication and conflict management skills.
- (6) Proactive monitoring of organisational data should be undertaken to identify patterns and outliers to help target interventions.

Lawyers and legal processes

- (7) NHS employers be mandated to establish appropriate and balanced procedures internally to ensure patient safety concerns are addressed and, in parallel, that individuals raising concerns are treated with positive fairness, encouraged and supported – to avoid whistleblowers needing to bring ET proceedings.
- (8) NHS employers to be under an obligation to notify the Secretary of State and the CQC (or Health Improvement Scotland ‘HIS’ as the case may be) whenever they (a) defend any case such in which a PIDA claim is made in the ET, or an equivalent claim (or defence) is put forward in civil proceedings; (b) bring or defend any related appeal; (c) where the employer knows or should know that a protected disclosure has been made which is claimed to be relevant to any employment dispute; and (d) reach any concluded compromise agreement in any case, falling within (a) to (c) above (together ‘notifiable cases’).
- (9) NHS employers to be under a similar obligation to notify the Secretary of State and the CQC (or, of course, HIS, as the case may be) whenever, in any notifiable case, they spend or agree to spend (say) £40,000 or more on legal fees and, again, when they spend or agree to spend £70,000 or more.
- (10) The Audit Commission to be provided with contact details of any individual to whom more than (say) £30,000 is offered or paid by way of compensation relating to any notifiable case.
- (11) The Secretary of State to adopt, across the NHS, the statutory Code on Whistleblowing as recommended by the Whistleblowing Commission.
- (12) The ban on gagging clauses over public interest issues should be reflected in and a clear statement from the Secretary of State (underpinned in law) that those who have previously been gagged can speak openly in the public interest. Disclosure to be made by employers of all gagging clauses (anonymised) by amount and legal fees incurred within last ten years and to then be published as part of a wider “truth and reconciliation” process.
- (13) A full review of PIDA, and access to funding for NHS whistleblowers, given the present shortcomings (reflected in the thematic review) including its provision of, at best, a chance of a retrospective remedy for the whistleblower who has suffered detriment, rather than preventing detriment and ensuring that the original concern is addressed.

Early intervention, investigation and protection

- (14) We have proposed to, and agreed with, NHS Employers an "Early Intervention" scheme whereby a named Trust Board member would take responsibility for ensuring that an immediate, quick and initial external review happens when significant concerns are raised, to establish whether patient safety is compromised or not. The CQC could be notified at that stage to record the health professional as a whistleblower, so their treatment could be monitored. NHS Employers have endorsed the proposal as a pilot and submitted it to the DH but nothing has been heard since February from the DH. We recommend a widespread, appropriately resourced piloting of this proposal involving staff organisations alongside Patients First.

Details of the **Early Intervention scheme** agreed with NHS Employers are attached in the letter sent to Caroline Waterfield, of NHS Employers, on 14th November 2013 at Annex 6 (on page 76).

- (15) A national hotline to the Department of Health or CQC to be established to log all concerns raised locally through whistleblowing procedures. This data is to be held purely as a record that concerns were raised.
- (16) The Secretary of State to authorise a process whereby staff who have raised concerns and suffer detriment may, with their agreement, be offered equivalent work elsewhere within the NHS as a "protected public interest whistleblower".
- (17) Any independent investigation report (including by professional bodies) to be published on the employer website and a copy given to any employee within the department involved. Names of individual staff may be redacted as appropriate but the report should not be otherwise edited.

Better Trust culture and accountability

- (18) Boards and regulators to give HR governance the same priority as Clinical governance, so that raising concerns becomes a safe, normal, course of action, in conformity with the professional obligations of health professionals. All Trusts to follow practice of the best Trusts, in which concerns (clinical incident reporting, informal discussion, formal concerns) are encouraged and addressed promptly. All Trusts to have a nominated Non-Executive Director responsible for patient safety including whistleblowing, proactively to follow up the progress of concerns and whistleblowing investigations, including how whistleblowers are supported.

- (19) NHS Board members of any organisation found to have materially obstructed, pressured or victimised whistleblowers to be held to account by the Secretary of State and/or Monitor/TDA. (To be integrated with the proposals for “fit and proper person” requirements for Board members across the NHS. The current consultation on *Strengthening corporate accountability in health and social care: Consultation on the fit and proper person regulations* should extend its remit to recommend a formal system of regulation for NHS general managers.)
- (20) All NHS organisations:
- (i) to provide training on how to raise concerns and what support is available to frontline staff at all levels to be provided to all staff;
 - (ii) to monitor the uptake of such training to ensure an adequate critical mass of employees have been so trained; and
 - (iii) as noted elsewhere: (a) to have clear arrangements for reporting back in a timely fashion to whistleblowers on how their concerns have been addressed; (b) to publicise to their workforce and tell the whistleblower about changes they have made to processes and policies as a result of whistleblowing; (c) to report on the effectiveness of whistleblowing arrangements in their governance statements in their Annual Report and Accounts.

Adapted from the Public Accounts Committee recommendation
www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/593/59304.htm

- (21) Where the identity of whistleblowers is known, employers must ensure that they are protected, supported and have their welfare monitored which should include (as noted elsewhere): (a) ownership from the top by assigning a board member who is accountable for the proper treatment of whistleblowers; (b) providing whistleblowers with appropriate support and advice, such as access to legal and counselling services; (c) appropriate and swift sanctions against employees, at all levels in the organisation, if they victimise whistleblowers.

Adapted from the Public Accounts Committee recommendation
www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/593/59304.htm

- (22) All measures to apply to private and third sector providers, delivering public services to or within the NHS.

Trust safety data and reporting systems

- (23) NHS staff survey reports for each employer to summarise outcomes relating to:

- (i) bullying and harassment;
 - (ii) reports on patient safety and care concerns raised, with staff feedback thereon; and
 - (iii) key staff engagement indicators;
- and NHS employers to email a link providing access to both that summary and the underlying data, to each member of their staff.
- (24) Boards to consider appointment of a Safety Ombudsperson or Ambassador with direct access to the Board as advocate/adviser for patients and staff raising concerns.
 - (25) Confirmation that any private contractor or third sector contractor undertaking NHS work above the NHS England standard contract “minor contract” threshold will be included in the next NHS staff survey and their results to be declared by employer.
 - (26) All NHS Trusts to have simple and effective incident reporting systems (of which the most common is DATIX) which can be used proactively, with proper and effective feedback, also feeding into the self-assessment of governance to be provided to the CQC.
 - (27) More serious patient incidents should be subjected to a root cause analysis to ensure adequate unit, and organisational, learning.
 - (28) Employers to improve data tracking to facilitate the identification of issues raised by whistleblowers, follow up of those issues and whistleblowers’ career progression – including asking whistleblowers about their views on the whistleblowing process.
- Adapted from the Public Accounts Committee recommendation
www.publications.parliament.uk/pa/cm201415/cmselect/cmpublicacc/593/59304.htm
- (29) Whistleblowers must be kept properly and regularly informed of the progress of issues they have raised and any related issues (such as investigation of them or their own related complaints e.g. detriments), as well as about any changes and improvements which have come about because of concerns they have raised.

Regulators

- (30) The CQC's formal reporting system for whistleblowing concerns raised within NHS providers and other NHS organisations (including national bodies) to publish a report annually as an anonymised report listing employers' reported data quantitatively or qualitatively.
- (31) Prior to CQC inspection, each employer to provide the CQC with: (a) its up to date whistleblowing policy; (b) a brief summary of how and when it was implemented and made known to staff; and (c) an audit of its effectiveness, including details and outcomes of investigations that have been triggered by whistleblowers and other relevant data to demonstrate how the procedure has been followed, including a self-assessment of its governance processes.
- (32) CQC inspections to include interviews with whistleblowers one year after they have raised concerns to audit their treatment subsequent to raising a concern, and to publish the outcome of these audits.
- (33) We endorse what we understand are the CQC's forthcoming pilot proposals for inspection to include identifying how whistleblowers are treated and the concerns raised by them addressed.
- (34) A sample of compromise agreements, under all categories, within each Trust to be audited by the CQC each year, including an interview with staff concerned, to check whether there are public interest issues, notwithstanding that the stated reasons are otherwise.
- (35) Professional regulators (GMC, NMC, HCPC, GDC) should explicitly support whistleblowers.
- (36) Employers must record, and their annual report must publish their records of, all whistleblowing cases, learning, outcomes – including what subsequently happened to (i) whistleblowers and (ii) anyone held to have subjected a whistleblower to detriment or sought to gag them – subject to any redaction of detail required by law.
- (37) The GMC to publish its internal confidential report on doctors who have died or committed suicide whilst under 'fitness to practice' investigation or procedures, suitably redacted as may be required by law.
- (38) Professional regulators to clarify to NHS employers the circumstances in which it is appropriate – and those in which it is inappropriate – to refer

registrants to them, specifying thresholds of conduct below which regulators would not expect referrals to be made.

- (39) All employers referring to any professional regulator registrants to be required to tell the professional regulator at the time of referral whether the registrant has made a protected disclosure and whether their doing so preceded the referral. In such circumstances, the regulator is required to seek to ensure that the referral is not wholly or partly in retaliation for making the protected disclosure and to establish and follow rules and procedures to exclude or reject such retaliatory referrals at an early stage.
- (40) Regulators to make specific provision in their rules that any medical or nursing director: (a) found to have been found complicit in gagging or causing detriment to anyone raising concerns, including retaliatory referrals of such staff to the regulator, to be guilty of professional misconduct; and (b) reasonably suspected of such misconduct to be referred to their own appropriate regulator by their employer, and the CQC notified thereof.
- (41) Whistleblowers and patient advocates to be encouraged to have a direct role in, or input into, management training nationally and locally.

Human resource departments.

- (42) In accordance with the CIPD Code of Professional Conduct and the expectations of all employers around whistleblowing, HR Directors and their staff, irrespective of whether they are CIPD registrants, are expected to
 - (i) 3.3 comply with prevailing laws and not encourage, assist or collude with others who may be engaged in unlawful conduct
 - (ii) 3.4 exhibit personal leadership as a role model for maintaining the highest standards of ethical conduct
 - (iii) 4.1 demonstrate and promote fair and reasonable standards in the treatment of people who are operating within their sphere of influence
 - (iv) 4.2 challenge others if they suspect unlawful or unethical conduct or behavior.

<http://www.cipd.co.uk/NR/rdonlyres/93D8886E-11CE-4D86-947A-639718C77BE4/0/codeofprofessionalconductfinaljan2012.pdf>
- (43) HR staff are expected positively: (a) to assist those raising concerns related to patient safety or other public interest concerns; (b) to seek to ensure that whistleblowers are not subjected to detriment or dismissal on the grounds

that they have made a protected disclosure; and (c) to assist staff challenging bullying at any time but in particular when linked to someone who has made or is considering making a protected disclosure (or supporting someone doing so).

Trade unions

- (44) Trade unions are encouraged to reflect on the Review report and recommendations. They should ensure that they never knowingly compromise patient safety, that they encourage their members to assert their professional accountability, and should give early determined support to those who do raise concerns (individually or collectively) and who as a result suffer any kind of attempt at gagging or detriment.
- (45) Trade unions should be expected to monitor and publish annually their involvement and support of good practice around the raising of concerns and their involvement with individual whistleblowers, including any professional regulator referrals.
- (46) The Social Partnership Forum should invite advice from whistleblowers on the effectiveness of the current policies and practice.

ANNEX 2: APPROACH OF EMPLOYERS

What constitutes whistleblowing and who PIDA “protects”?

1. NHS Employers appear to be under a fundamental misapprehension as to both the definition of a whistleblower and the scope of the protection afforded by the Public Interest Disclosure (PIDA) provisions in the Employment Rights Act 1996.

2. For example Dean Royles, Chief Executive NHS Employers, said the following only two months ago:

“There is a difference between raising concerns, which many staff do every day, and blowing the whistle outside the organisation, which PIDA would protect them from. Part of the debate has become confused, in that we sometimes say whistleblowing when we mean raising concerns, and we sometimes say raising concerns when we mean whistleblowing, but we know from all the surveys that come out that something like 90% of staff know how to raise a concern; the vast majority of them feel safe to do so; staff say they are encouraged in their organisations to raise concerns..... we have to avoid the confusion between staff not feeling able to raise concerns and what sometimes gets referred to as whistleblowing.”

Dean Royles, Chief Executive NHS Employers. Health Committee Oral evidence: Complaints and raising concerns, HC 350. Tuesday 8 July 2014 Q437

3. This betrays a fundamental misunderstanding of both whistleblowing and PIDA. It is not just a misunderstanding of the legal provisions, but also a material misreading of policy explanations in the public domain, such as the following definition of whistleblowing:

“... when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including: someone's health and safety is in danger.”

Source: <https://www.gov.uk/whistleblowing/overview>

4. As pointed out on page 3, in the Summary, this largely mirrors the Public Interest Disclosure Act provisions ('PIDA') inserted into the Employment Rights Act (save that the report can also be about a breach of duty that is *likely to happen*, and must be reasonably believed to be in the public interest). However, PIDA makes no distinction between “raising concerns” and whistleblowing” and no distinction between whether the concerns are raised internally or externally. What counts is whether the concern meets any of the categories set out above. NHS Employers' approach is fundamentally flawed in this respect.

5. However, this does perhaps explain the incidence of whistleblowers feeling that they are not provided with proper support.
6. No one knows what proportion of “concerns” that are raised meet the conditions set by PIDA but it will be a large number, since many include a breach of a duty of care by the employer, a member of staff or a contractor.
7. Equally important, almost all concerns that are raised, including those that fall within the PIDA categories, are raised as concerns internally, through DATIX, with line managers or in other internal methods. A very small proportion indeed will be raised through the employer’s internal whistleblowing procedure.
8. Why is this important? Because defining whistleblowing as “blowing the whistle outside the organisation” radically reduces the scale of the apparent problem by counterposing staff who go outside the organisation to those who raise concerns internally. In reality, these are almost always the same people since very few staff raise concerns outside the organisation without having first tried to raise them internally. Indeed NHS Trust “whistleblowing policies” are explicitly designed for internal use.
9. Public Concern at Work’s research explains that staff who raise a concern more than once – perhaps because they are one of the many who never get a response to their initial concern – are especially at risk.
10. The category of staff whose treatment should be considered are those who raise a concern that is either rebutted, or ignored, leading them to have to raise it again. A significant proportion of such staff are subject to detriment or the threat of it. There is no data kept by employers so the precise size is not known.
11. If NHS Employers’ evidence to the Francis Review were to be premised on such a confusion it would inevitably, and incorrectly, minimise the scale of the problem to be addressed. Furthermore, the absence of whistleblowing and whistleblowers (because they are all too afraid to speak up) is far from being evidence of there being no problem.

“Definitely in a better place”?

12. The suggestion by NHS Employers that we are definitely in a better place in which staff feel safe to raise concerns is one which is fraught with difficulty, not least when different surveys show very different figures. The ‘better place’ line has been very much part of the message from NHS Employers:

“We are definitely in a better place, aren’t we? But there is a lot more to do. If you look at the staff survey and the results around bullying, they are not good enough. If you look at the staff survey, 10% of staff do not feel safe to raise concerns, and that is not good enough. We need to be addressing these cultural issues.”

Rob Webster. Chief Executive NHS Confederation. Health Committee Oral evidence: Complaints and raising concerns, HC 350. Tuesday 8 July 2014 Q436

“Rob Webster: Let us go back. The generality is different from that, isn’t it? The generality is one and a half million incidents raised by staff—some of them serious harms, some of them moderate, the majority minor or no harm. So we are in a culture where the generality is that people do raise incidents and concerns every day, and the vast majority of staff know how to do it, do it and feel that they are encouraged by their organisation to do it.”

“Dean Royles: we know from all the surveys that come out that something like 90% of staff know how to raise a concern; the vast majority of them feel safe to do so; staff say they are encouraged in their organisations to raise concerns.”

Both giving Health Committee Oral evidence: Complaints and raising concerns, HC 350. Tuesday 8 July 2014 Q439

13. The NHS staff survey tells us:
- 90 per cent of staff know how to raise a concern
 - Most feel safe to do so (10 per cent do not – and that’s 10 per cent too many)
 - 90 per cent of staff who saw issues affecting care say they raised them
 - 60 per cent reported they had not received feedback. This is a significant issue.

14. The emphasis upon the feedback problem alone tends to both overshadow and obscure the underlying and more serious concerns over treatment of whistleblowers. Yet that emphasis is fairly consistent and very well publicised. For example:

“We are not particularly good at getting back to staff when they do raise concerns. If we look at the staff survey results, for example, something like 54% of people say that people do not get back to them, and I think that is the area we have to focus on, but it is about the raising a concern issue rather than the whistleblowing issue.”

We need a new language around whistleblowing, by Dean Royles. The Guardian. 21 March, 2014

NHS staff surveys since 2010

15. The national NHS staff survey reports from 2010 (the First Francis Report) onwards show:
- The “Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month” has been stable since 2009 at 30%, the “Percentage of staff reporting errors, near misses or incidents witnessed in the last month” has fallen from 97% to 90% since 2011. It is unclear why but it hardly suggests things are getting better.
 - Bullying and harassment of staff in the last two years is at a record high having risen sharply in recent years (23% in 2012, 22% in 2013) and it is a shared view of Patients First and NHS Employers that bullying is a serious obstacle to the raising of concerns.
 - The proportion of staff agreeing that “My trust encourages us to report errors, near misses, or incidents rose from 81% (2010) to 85% (2013)
 - “My trust blames or punishes people who are involved in errors, near misses, or incidents” rose from 11% (2010) to 14% (2013) even though the proportion disagreeing rose by a similar amount to from 39%(2010) to 42% (2013)
 - The proportion of staff agreeing that “ When errors, near misses, or incidents are reported, my trust takes action to ensure that they do not happen” rose from 55% (2010) to 62% (2013) but the numbers disagreeing also rose from 5% (2010) to 7% (2013) and 32% “didn’t know”
 - The proportion of staff agreeing to the question “Would you feel confident that your organisation would address your concern?” was static at 56%
 - Just 62% of staff agreed that “When errors, near misses, or incidents are reported, my trust takes action to ensure that they do not happen again.”
 - Just 44% of staff agreed that “We are given feedback about changes made in response to reported errors, near misses and incidents”.
 - Only 72% of staff answered YES when asked “Would you feel safe raising your concern?”

Kings Fund survey 2014

16. The more recent authoritative *Kings Fund Culture and leadership in the NHS survey (May 2014)* was more worrying:

- When asked whether their organisation was characterised by openness, honesty and challenge, responses were evenly split 39% for and against. However, there was a remarkable difference between Board members (84%) and doctors (37%) and nurses (31%).
- When asked if they were positive about raising concerns about how services are provided there was a similar sharp difference between Board executives (94%) and doctors (66%) and nurses (57%).
- Only 40% of staff overall felt concerns they raised would be dealt with appropriately but again there was a sharp difference between Board members (90%) and their own senior managers (55%) doctors (36%) and nurses (26%).
- When asked if swift and effective interventions were taken to deal with inappropriate behaviours and performance only 30% answered yes, and 43% answered No. Even only 58% of executive directors responded positively.

17. The Kings Fund survey concluded:

The most notable feature of this year's survey results was a consistent discrepancy between the views of executive directors and those of other NHS staff especially nurses and doctors.

Nursing Times survey 2014

18. The Nursing Times survey of March 2014 detected some positives but was also concerning in some important respects:

- In line with the NHS national staff survey, 50% of those respondents who raised a concern said it did not lead to an "appropriate outcome", compared with 30% that said it did and 20% who did not know.
- More worrying still, 47% said that raising a concern had resulted in "negative consequence" for them personally – though 9% also said it had led to "positive consequences".

- Asked whether the culture of their organisation had changed over the last 12 months, 37% said it had improved “significantly” or “a bit”. However, half reported no change and, worryingly, 13% said things had “deteriorated”.
Survey shows NHS is not there yet on raising concerns, by Steve Ford, , Nursing Times, 6 March 2014 – see also: Is NHS culture improving post the Francis Report? by Shaun Lintern, Nursing Times 3 March 2014
19. Perhaps the most worrying point to emerge from all the surveys, is what the King’s Fund called “the most notable feature of this year’s survey results” which was the consistent discrepancy between the views of executive directors and those of other NHS staff especially nurses and doctors.
 20. It is unclear whether this discrepancy derives from a fundamental lack of understanding of the basic concepts involved (as might be suggested by Dean Royles’s evidence to the Health Select Committee), from institutional filtering of reporting up the chain or a lack of proper reporting, or from Nelsonian blindness by executive directors or worse.
 21. What is clear is that until everyone is working on the basis of common definitions and approaches to whistleblowing, systemic failings will not be overcome.

ANNEX 3: LITERATURE REVIEW

1. This part of our submission summarises:
 - The importance of workplace culture in healthcare
 - The link between patient safety and bullying
 - The evidence on whether NHS patient safety culture is improving
 - The background evidence on the treatment and protection of whistle-blowers
 - The role of those agencies that staff who raise concerns should be able to rely on

The importance of workplace culture in healthcare

“If the culture is unethical, acts of heroic staff may be futile.”

Ann Gallagher, 13 September 2011 Nursing Times

2. The First Inquiry Report into Mid Staffordshire NHS Foundation Trust (2010) concluded that the Trust culture was not conducive to providing good care for patients or providing a supportive working environment for staff for several reasons including:
 - bullying – an atmosphere of fear of adverse repercussions in relation to a variety of events was described by a number of staff witnesses. Staff described a forceful style of management (perceived by some as bullying) which was employed on occasion;
 - target-driven priorities – a high priority was placed on the achievement of targets, and in particular the A&E waiting time target. The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack;
 - disengagement from management – the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans. There was also a lack of trust in management leading to a reluctance to raise concerns;

- lack of openness – before obtaining Foundation Trust status, the Board conducted a significant amount of business in private when it was questionable whether privacy was really required. One particular incident concerning an attempt to persuade a consultant to alter an adverse report to the coroner has caused serious concern and calls into question how candid the Trust was prepared to be about things that went wrong;
 - denial – In spite of the criticisms the Trust has received recently, there is an unfortunate tendency for some staff and management to discount these by relying on their view that there is much good practice and that the reports are unfair. (Francis: Vol I. Executive summary. Para 43.)
3. The First Inquiry Report concluded that excessive workloads, inappropriate skill mix, and a bullying culture contributed to the normalisation of appalling treatment. It stated “an explanation for staff’s reluctance to come forward with concerns was that they were scared” (Francis: Vol I. B. 37. (2010)). Witnesses described “an ‘endemic culture’ of bullying” (Francis: Vol I. B. 38 2010)) with graphic examples of the victimisation of those who did raise concerns.
 4. The “Speaking Up” Charter (2012), intended to anticipate the Public Inquiry Report (2013), called on all NHS leaders to work towards

“a just culture which is open and transparent. A just culture ensures individuals are fully supported to report concerns and safety issues, and are treated fairly, with empathy and consideration, when they have been involved in an incident or have raised a concern.”
 5. In a recent comprehensive analysis of “culture and behaviour in the English National Health Service” Mary Dixon-Woods and colleagues (2013) wrote

“Culture” is itself a contested term, but all definitions have in common have in common “an emphasis on the shared basic assumptions, norms, and values and repeated behaviours of particular groups into which new members are socialised, to the extent that culture becomes ‘the way things are done around here’”.
 6. For sharp-end staff, threats to safety and quality were identified as weaknesses in systems, failures of reliability, suboptimal staffing, inadequate resources and poor leadership. Lack of support, appreciation and respect, and not being consulted and listened to were seen as endemic problems by staff in some organisations. (Dixon-Woods M et al. BMJ 2013)
 7. High levels of “staff engagement” are associated with improved patient outcomes and staff performance. The precise nature of staff engagement is a matter of debate but most recent research regards engagement as a psychological state associated with involvement in one’s work and feelings of commitment and loyalty to one’s

- organisation. Academic research suggests that such engagement affects staff behaviour, and consequently influences both their individual and their organisation's performance.
8. Dixon-Woods M et al (2013) found lower levels of mortality were associated with:
 - higher levels of staff engagement;
 - higher levels of staff health and wellbeing;
 - staff reporting support from line managers;
 - well structured appraisals (e.g. agreeing objectives, ensuring the individual feels valued, respected and supported); and
 - opportunities to influence and contribute to improvements at work.
 9. In contrast they found that less satisfied patients, and Care Quality Commission ratings describing poorer care and poorer use of resources, were associated with
 - places where staff reported high work pressure;
 - poor staff health and wellbeing;
 - high injury rates; and
 - high levels of staff intention to quit their jobs.
 10. They concluded that

"the wellbeing of staff is closely linked to the wellbeing of patients, and staff engagement is a key predictor of a wide range of outcomes in NHS trusts. Achieving high levels of engagement is only possible in cultures that are generally positive, when staff feel valued, respected and supported, and when relationships are good between managers, staff, teams and departments and across institutional boundaries"
 11. West and Dawson (2011) use NHS staff survey and patient survey data to analyse the links between staff engagement, patient experience and outcomes. They found that engagement is significantly linked to patient mortality in NHS acute trusts, both when mortality is measured in the same year as engagement, and when it is measured in the subsequent year. Staff engagement was also found to be a critical factor in explaining absenteeism and staff turnover. They found engaged staff were more likely to be able to show empathy and compassion to patients, despite work pressures and that high

- engagement was positively correlated with better patient experience and a higher proportion of patients reporting that they were treated with dignity and respect.
12. The Keogh Review (2013) underlined the research about staff engagement stating “we know from academic research that there is a strong correlation between the extent to which staff feel engaged and mortality rates. (Keogh, B (2013))
 13. In *Understanding Patient Safety* (2012), Robert Wachter, a leading patient safety expert, summarises some of the evidence that “safety culture correlates within clinical outcomes including infection and readmission rates”. Like West and Dawson he considers the importance of “authority gradients” which may be natural, but become dangerous

“when they prevent caregivers with important knowledge or concerns from sharing them with superiors for fear of being wrong or angering the boss.....safe organisations find ways to damp down hierarchies at all levels, encouraging individuals (including patients) to speak up when they see unsafe conditions or suspect that something might be awry.” (Wachter, R (2012))
 14. Wachter sets out, as a key strategy to improve patient safety, the need to “dampen authority gradients” and describes simple ways in this can be done “such as having the leader introduce him or herself, learn the name of the other workers, admit his or her limitations and explicitly welcome input from other members of the team.

“You’ll know you’ve achieved a safe culture when you see someone low in the hierarchy – say a new nurse – reminding a senior physician to wash his or her hands, and the physician responds by simply saying “thank you|” then turns to the sick or gel dispenser”
 15. Wachter concludes

“Safe cultures are ones in which people willingly speak up when they see risky situation and behaviours, there are relatively flat hierarchies, workers follow critical safety rules and the need for throughput is balanced against the need for safety.”
 16. Beverly Alimo-Metcalfe evidences that a move away from a top down leadership model led by “heroic” (or macho) managers in which there is a sharp authority gradient towards one in which there is a much more distributed leadership model improves healthcare outcomes (Alimo-Metcalfe B, Alban-Metcalfe J (2008); Alimo-Metcalfe B (2012)).
 17. An evidence review into the “lack of compassion” commissioned by NHS NW concluded:

“The evidence overwhelming demonstrates, that health staff do not enter their professions to cause harm. Research shows compassion, empathy, dignity and respect to

be core nursing values..... Organisational culture, policy and politics can exert a damaging influence on caring values.”
Source: Flynn, M. Mercer D (2013)

18. The Secretary of State for Health appeared to understand how the immense pressures on staff can “normalise” unacceptable and unethical behaviour when he said the NHS
“must ensure that training for nurses and care assistants helps them cope with busier wards – and that the compassion that led them into the profession does not get ground out of them”. (The Telegraph, 6 January 2012).
19. The Chief Nursing Officer rightly called for nurses to have the “courage” to speak out when a lack of compassion, poor or unsafe care exists or is likely to. (DH. Compassion in practice (2012)) but such courage may trigger serious risks to the detriment, employment, career or health of those who do so.

Patient safety and bullying

20. The annual NHS staff survey reports that between 2005 and 2011 some 14% to 18% of staff reported experiencing harassment, bullying or abuse from other staff in the previous 12 months. The same survey reported a significant increase in such bullying, rising from 14% in 2010 and 2011 to 23% (2012) and 22% (2013).
21. West et al (2012) reported that bullying, discrimination, and overwork lead to disengagement and “are likely to deprive staff of the emotional resources to deliver compassionate care.” They reported
- a strong negative correlation between whether staff report harassment, bullying or abuse from other staff in the NHS staff survey and overall patient experience
 - a strong negative correlation between whether, in the NHS staff survey, staff reported harassment, bullying or abuse from other staff and whether patients reported being treated with dignity and respect
22. They also found that engaged staff were more likely to intervene to raise concerns about safety or address poor behaviours. Their analysis of the NHS staff survey shows a strong positive correlation between staff engagement and the percentage of staff reporting that they reported errors, near misses or incidents in the past month in the NHS staff survey for 2012. They concluded
“Engaged staff may provide our most efficient mechanism for addressing negligence or poor standards of care.”

23. The growing and widely reported gap between available resources and patient need may well increase the need for a culture in which staff can safely raise concerns
24. Don Berwick (2012) emphasised the importance of the staff voice:
- Each organisation should be expected to listen to the voice of staff, such as through department and ward level cultural and teamwork safety surveys, to help monitor the safety and quality of care and variation among units. Staff should all be free to state openly their concerns about patient safety without reprisal. There is no place for compromise agreements (“gagging clauses”) in such cases
25. There is a wealth of research and surveys confirming that bullying is a serious problem, that it has been increasing in the NHS and that it is a key factor (arguably the key factor) in deterring staff from raising concerns. Our accompanying background paper sets out some of the evidence.
26. Though all NHS employers have “dignity at work” procedures whose stated purpose is to deter bullying and harassment, surveys suggest these may well not be effective. Such staff survey views may be influenced by a belief that:
- NHS Trusts, anecdotally, have very low rates of upholding complaints against managers for bullying.
 - Virtually no examples are known of bullied whistleblowers who were subsequently promoted.
 - Human Resources’ role is rarely reported as being supportive of those raising bullying concerns once a formal process is commenced.
27. The Inquiry into baby deaths at Bristol Royal Infirmary a decade ago warned of the impact of bullying and in 2009 Sir Ian Kennedy, who chaired that Inquiry that bullying is “permeating” patient care.
- “One thing that worries me more than anything else in the NHS is bullying.....“We’re talking about something that is permeating the delivery of care in the NHS.”
- Source: Santry (2009)*
28. Evidence commissioned by Lord Darzi in 2008 concluded there was a “pervasive culture of fear in the NHS and certain elements of the Department for Health” (Joint Commission International; Quality Oversight in England (2008)). Nevertheless, the Public Inquiry Report 2013 accepted the evidence of DH witnesses who dismissed that evidence.

29. NHS Employers subsequently commissioned a survey of 3,000 staff at seven trusts in the North East. Dean Royles, director of NHS Employers rightly drew from that report that:

“trusts need to develop cultures whereby barriers are recognised and addressed, policies are seen as effective, and each report of bullying is treated seriously. It highlights cultural barriers that stop people reporting bullying; 14% of staff said they did not want to be seen as a troublemaker, while 11% were concerned that this would make the situation worse. A similar proportion of staff said nothing would change and that they would not report a bully who was more senior than them.”

30. An organisation can struggle to tackle bullying if it is rarely reported. Robust staff engagement and encouraging a culture of openness and trust are key in addressing under-reporting. Confidence to report bullying is directly related to confidence to report workplace concerns. (Dean Royles (2011))

31. In the same year, a survey of 81 NHS chief executives suggested that the culture of fear reported to Lord Darzi three years previously still pervaded the NHS:

“Many respondents describe a ‘bullying culture’ ... NHS Confederation chief executive Mike Farrar said that although he was worried by the working culture reflected in the survey results he was not surprised by the comments.”

“Bullying is a word whispered in the NHS. Nobody wants to operate under a climate of fear and everybody needs to have a zero tolerance approach.” (Lintern (2012))

32. The 2013 NHS staff survey, which confirmed that the 2012 increase in the proportion of staff reporting bullying by colleagues and managers had been sustained, also noted that staff surveyed said less than half of cases of bullying, harassment or abuse cases were reported. The proportion of cases being reported is also falling, down from 54% in 2004 to 44% last year.

33. The most comprehensive UK literature search and analysis of the causes and responses to bullying in the NHS was published last year. J.C. Illing et al (2013) distinguish between social or group approaches which have focused on interactions within a group that can lead to bullying; and organisational approaches which seek to take a more holistic view of bullying, viewing the system at the root of the problem rather than an individual or group. They found that

“empirical evidence has found higher levels of bullying in times of organisational change, in hierarchal organisations, in the presence of destructive leadership styles, and where bullying goes unchecked through lack of disciplinary action.”

34. The 'fear of consequences' was given as the most common reason doctors feel the process for raising concerns is ineffective and many also experience a lack of support from their organisation. (MPS 2012)
35. Some staff suffer bullying more than others, particularly those with protected characteristics notably black and ethnic minority staff and disabled staff. There is now extensive research on the scale, nature and consequences of bullying in healthcare, especially for doctors and nurses and we evidence that in our supplementary submission. It notably affects doctors and the nursing/midwifery professions from the beginning of their training through to their leaving the NHS. The national staff survey reports bullying affects doctors and nurses as much as it does other professions.
36. One writer noted recently:
- "One could forgive an outsider's bemusement at how it is that a modest number of NHS managers succeeded in creating such a hostile environment that only 11% of doctors have confidence in whistleblowing protection. If the majority of the powerful in medicine (which includes doctors as well as managers) believed that whistleblowers were a gift rather than a curse to the profession then the culture of fear would be overthrown and the problem would cease to exist." Source: Evans, C (2012)
37. There is now a wealth of evidence about the impact on patient care and safety of a bullying culture, both directly, and indirectly through the increased reluctance to raise concerns or admit mistakes.
38. The US Joint Commission is an independent, non-profit organisation that accredits health care organizations and programmes. In 2008, it issued a Standard on "intimidating and disruptive behaviour at work", citing concerns about patient care entitled "Behaviors that undermine a culture of safety". Source: JCI (2012)
39. The new Standard set out some of the extensive evidence that intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. It stressed that safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. The Standard states:
- to assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team. Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviours include reluctance or refusal to answer questions, return phone

calls or pages; condescending language or voice intonation; and impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

40. In the UK, the confidential Philips Report at Alder Hey, for example, show the serious consequences for patient safety that can flow from bullying. This is far from an isolated bullying example, as recent evidence from the nearby Christie Hospital NHS Foundation Trust Christie and Liverpool Women's Hospital confirm.
41. The 2012 and 2013 GMC junior doctor survey findings on bullying have finally prompted the current GMC consultation on "concerns about doctors" (GMC August 2014) to highlight "Improved public protection in cases where a doctor has bullied colleagues and put patients at risk or discriminated against others in their professional or personal life." We welcome this. There is no evidence that existing approaches to bullying across the NHS as a whole have been successful; rather, despite long standing evidence of the significant damage bullying causes, reported levels have grown very substantially in recent years.
42. Patients First believe it is now time for an authoritative and similar requirement to the JCI Standard from the DH which employers are expected to apply with the support of professional regulators.

Is NHS patient safety culture improving?

43. Considering the impetus provided by the Mid Staffordshire NHS Foundation Trust Inquiry Reports of 2010 and 2013 and subsequent Ministerial statements, the Speaking Up Charter, the survey evidence suggests a very mixed picture with very limited progress over the last four years since the 2010 Inquiry Report.
44. Despite the reassuring tone of some of the evidence to House of Commons Select Committees from the Department of Health and NHS Employer, recent NHS staff surveys since both the Mid Staffordshire NHS Foundation Trust Inquiry report and the final Public Inquiry report suggest the NHS still has a long way to go to make staff confident about raising concerns and end the detrimental treatment of some of those who do.
45. The most recent sector wide survey is the Kings Fund May (2014b) annual Culture and leadership in the NHS survey. It concluded:

46. The most notable feature of this year's survey results was a consistent discrepancy between the views of executive directors and those of other NHS staff especially nurses and doctors.
47. Specific responses on the raising of concerns reflected that general concern:
- When asked whether their organisation was characterised by openness, honesty and challenge, responses were evenly split 39% for and against. However, there was a remarkable difference between Board members (84%) and doctors (37%) and nurses (31%).
 - When asked if they were positive about raising concerns about how services are provided there was a similar sharp difference between Board executives (94%) and doctors (66%) and nurses (57%).
 - Only 40% of staff overall concerns they raised would be dealt with appropriately but against there was a sharp difference between Board members (90%) and their own senior managers (55%) doctors (36%) and nurses (26%).
 - When asked if swift and effective interventions were taken to deal with inappropriate behaviours and performance only 30% answered yes, and 43% answered No. Even only 58% of executive directors responded positively.
48. Since 2010, the NHS national staff survey reports:
- Overall levels of "staff engagement" in the NHS, an aggregate score comprising scores for staff motivation, perceived ability to contribute to improvements at work, and willingness to recommend the organisation as a place to work or receive treatment) have improved over the last decade rising from 3.68 (2012) to 3.74 (2013) albeit with a widening gap between the better Trusts and the rest.
49. Separate Kings Fund research suggests a concerning trend:
- "The disparities between providers participating in the survey appear to have increased over at least the past four years. While the average overall engagement score increased across the NHS from 2011 to 2013, growth has been faster within providers with scores in the median and top quartiles. (The variance in overall engagement scores increased by 65% from 0.02 to 0.033 from 2011 to 2013.) So the distance appears to be widening, with those providers with lower levels of staff engagement falling further behind the leaders."
- (Source: Kings Fund, 2014)

50. Overall, the NHS national staff survey reports since the First Mid Staffordshire NHS Foundation Trust Inquiry Report in 2010 have been distinctly mixed on the raising of concerns.

- The proportion agreeing their Trust treats them fairly if they are involved in an error, near miss, or incident fairly has increased but so has the proportion not agreeing.
- The numbers believing their Trust blames or punishes people involved in errors, misses or incidents has increased by the same amount as those who believe the opposite.
- The numbers believing that, when errors, near misses, or incidents are reported, their Trust takes action to ensure that they do not happen again, has increased but so have the numbers believing the opposite.
- The numbers reporting they are given feedback about changes that are made in response to reported errors, near misses and incidents has increased but remains very high.
- The proportion saying they would feel safe raising concerns did not change between the period six months prior to the Public Inquiry Report and six months after its publication. 28% remain unable to say they felt safe raising concerns (not asked 2010-11)
- The proportion who felt confident their organisation would address their concerns slightly improved but 44% still felt unable to say they were confident their organisation would address their concerns (question was not asked in 2010 and 2011).
- A comparison of the proportion of staff witnessing potentially harmful errors, near misses or incidents in the last month and the proportion who actually reported them suggests that the proportion of staff reporting harmful errors, near misses or incidents in the last month may have significantly dropped since 2011.
- The proportion of staff reporting bullying by colleagues and managers had substantially increased in the four years from 2010 onwards. In 2013, 22% of staff reported they had experienced bullying, harassment or abuse from either their line manager or other colleagues. This was slightly lower than the year previously, which had been an all time high but well above previous years. Staff surveyed said less than half of the cases of bullying, harassment or abuse cases

were reported. The proportion of cases being reported is also falling, down from 54% in 2004 to 44% last year.

51. As detailed extensively in our supplementary submission other independent surveys of nurses, nursing students and junior doctors reported broadly similar findings about the fear of raising concerns and on bullying.

Anecdotally, some NHS employer organisations are certainly taking on board the lessons of the two Inquiry Reports. The data suggests however that the evidence to Parliamentary Select Committees from NHS employer organisations in 2013-14 was over-optimistic. The extensive survey data referenced in detail in our supplementary submission suggests caution is appropriate in drawing any evidence of a step change in culture and practice. The most significant developments may be that despite the 2010 and 20113 Inquiry Reports and subsequent policy initiatives and declarations that change is slow and patchy accompanied by tentative evidence of a growing gap between the better and the worst organisations.

The treatment and protection of whistle-blowers

52. In evidence to the Health Committee (July 8th 2014) NHS Employers made a sharp distinction between staff who raise concerns (internally) and whistleblowers (who raise concerns externally). Such a distinction is fundamentally flawed, as set out in Annex 2 above.
53. In fact almost all staff begin by raising concerns internally either with their local manager or work colleagues or through an incident reporting system such as Datix. Staff then use a “whistleblowing policy” when their initial approach fails (no response or no appropriate response) and they have to avail themselves of their Trust whistleblowing policy or go outside the Trust to use, for example, the CQC whistleblowing policy or the NHS “whistleblowing helpline”. The proportion of staff who go outside their own employer to raise concerns with a regulator or the media is miniscule.
54. As Patients First our concerns are primarily about what happens to those who raise concerns and who, faced with silence, inappropriate responses or detrimental treatment may (or may not) then use more formal policies internally or externally. Some (possibly many) of these concerns will be ones which meet the threshold of the Public Interest Disclosure Act though not all may do. Neither the law, nor research, recognises the distinction NHS Employers make.
55. Public Concern at Work (2013) (PCAW) analysed the experiences of 1,000 ‘whistleblowers’ in a recent cross sectoral analysis. They found that

- the typical whistleblower is a skilled worker or professional who has been working for less than two years, who is concerned about wrongdoing that is on-going and affects wider society, and has been occurring for less than six months.
 - employers have up to two opportunities to listen to staff as the concern is usually raised at most twice with line then middle management.
 - whistleblowers are most likely to experience no response from management either to them personally or to the concern that has been raised.
 - whistleblowers in the health sector have low trust in the investigatory process and in only 6% of cases was the wrongdoing reported then stopped.
56. PCAW then examined the consequences for healthcare staff who made a second attempt to raise a concern because the initial attempt was seen as unsuccessful. They found
- those who raise concerns more than twice are at serious risk of suffering detriment
 - the NHS is at least as unsafe an environment to raise concerns as other sector
57. The report *'Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients'* (2006) found:
- “...that there was something of a climate of fear and retribution, so that any lapse in performance or simple human error was seen as punishable by suspension, disciplinary action and referral to the General Medical Council. This remains the case today.”
58. Patients First is aware that “retaliatory referrals” for doctors and nurses occur in whistleblower victimisation, whilst suspension is common despite the Court of Appeal specifically cautioning against its inappropriate and excessive use. (Crawford & Anor v Suffolk Mental Health Partnership NHS Trust [2012] EWCA Civ 138, [2012] IRLR 402,125 BMLR 23).
59. There have been numerous exhortations, policies and declaration from Ministers and NHS Chief Executives stressing the importance of whistleblowing since the Public Interest Disclosure Act 1998 (PIDA) became law culminating in the DH response to the Francis Report, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-I (19 November 2013) which stated

“2.15. Many of the measures set out in this response are designed to ensure that the NHS is a genuinely open and transparent culture, a culture that will make whistleblowing far less necessary than at present.”

60. The recent steps taken include statutory and regulatory changes, and changes to the NHS Constitution, the abolition of gagging clauses and amended Standards for members of NHS boards and governing bodies in England (2012, CHRE). The emphasis on relatively minor legal changes – at least one of them in response to a detrimental court decision which the NHS itself originally funded (Fecitt) – fails to address the fundamental problem of culture and bullying. Few NHS cases ever reach the courts partly because the cost of doing so – financially and personally – is immense and partly the chances of ever appearing in court are slim. Trade unions and insurers pursue very few cases as they judge the likelihood of winning to be low given the narrow interpretation the courts have made of the PIDA provisions.
61. It is now sixteen years since HSC 1998/1999 first sought to protect NHS whistleblowers post PIDA. It surely says something about the resilience of NHS employers in avoiding the protection of whistleblowers that so many letters, circulars and declarations of intent have been necessary to try to provide the protection that the law expects and which the evidence says is good for patient care.
62. PIDA does not make voicing concerns any easier for workers, for example by providing a statutory mechanism for whistleblowing and the fear staff feel, about speaking out on public interest issues, remains.
63. PIDA places no statutory obligations on organisations once a concern is raised. An obligation that concerns must be investigated speedily within a certain time limit could save lives. PIDA does not even provide that a concern must be investigated.
64. The healthcare provider, not the Tribunal, is responsible for investigating and addressing patient safety concerns in a thorough and timely manner so as to stop malpractice and discharge their duty of care to service users.
65. PIDA is reactive, providing a remedy for damage that has already been caused. It does not prevent reprisals.
66. PIDA requires litigants to fund the expense of exercising their rights before the Employment Tribunal but whistleblowers are generally already at risk of losing their employment, may have been dismissed, and are in financially precarious circumstances. The introduction of Tribunal fees has added another disincentive, even before legal fees, especially when challenging aggressive, well-funded Trust lawyers.

67. Though the Public Interest Disclosure Act 1998 was drafted to provide protection for public interest whistleblowers, in practice, and apparently especially in the NHS, PIDA has been at best a source of remedy, not protection, despite the universal use of internal whistleblowing procedures within NHS organisations.
68. Even if a whistleblower (through their union or insurance) can fund an Employment Tribunal claim, whistleblowers must firstly show that they meet the statutory test of having made a “protected disclosure”, that they have suffered a detriment, and that the detriment arises from their having made the protected disclosure. Given the obvious evidential problems this presents, this is difficult for specialist lawyers to achieve, and almost impossible for a litigant in person.
69. The chances of whistleblower litigants getting another similar job are very poor even if they win. The likelihood of those who victimise whistleblowers being held to account appears close to vanishing point.
70. About half of NHS staff who say they raised concerns got no response; over one quarter of staff are unable to say they have confidence it is safe to raise concerns; almost half of those nurses who did raise concerns say they suffered a detriment. In our experience the most common response of too many employers towards staff who raise concerns which have not been addressed and who then seek to pursue them is to turn a patient safety/care dispute into an employment dispute.
71. An academic authority on whistleblowing confirms our own experience:
“Empirical research consistently shows that the two main reasons why people do not report perceived wrongdoing are fear of retaliation and a belief that even if they do the matter would not be rectified. *Source: Lewis, D (2013)*”
72. Those staff who do raise concerns having had no response or inappropriate ones and then pursue their concerns further commonly face a process we describe as the “Lifecycle of the Whistleblower” (see our supplementary submission) in which all manner of direct and indirect threats and pressures are placed upon a significant number of staff who have or wish to raise concerns.
73. The Public Accounts Committee (2014) recently reported:
10. We asked Una O'Brien about what has happened to people who had made threats and perpetrated bullying against whistleblowers, and whether any disciplinary action had ever been taken against people for these actions. Una O'Brien was unable to provide any information as the Department did not collect it from NHS employers. Una O'Brien said that there were such cases locally, and accepted that the Department had not brought these to the fore, or made them visible in the public domain. Una O'Brien agreed to consider whether this could be done.

11. Public Concern at Work told us that it was rare for someone who has victimised a whistleblower to be sanctioned, and that it was only aware of one case where this had happened, which was at the Mid Staffordshire NHS Foundation Trust. The other departments were also unable to give us any concrete examples of where they had taken disciplinary proceedings against an employee who had victimised a whistleblower.

74. It may be that the new statutory duty of candour and the NHS Outcomes Framework can assist the protection of staff raising concerns where an NHS employer can be demonstrated to have obstructed or victimised a such a member of staff such that the chief executive may risk criminal charges and may be regarded as no longer fit to be a board director in any NHS organisation. We hope so, for were that to happen it might help signal to the sector that culture change is unavoidable.
75. The recent case (Fernandez) involving an NHS private sector contractor was a reminder that it is important that private contractors providing NHS services comply with the NHS Constitution (as the NHS standard contract requires them to) and with the Speaking Up Charter, the ban on gagging clauses and that other measures around the duty of candour will be monitored and enforced for the growing number of private contractors.
76. In summary, if sufficient employers continue to turn a public interest issue into an employment issue in which the conduct or competence of the member of staff raising a concern becomes the issue not the public interest concern they originally raised. There is still nothing to stop a determined employer:
- Identifying matters of conduct or competence after a member of staff has raised a public interest concern but which supersedes it procedurally
 - Suspending or otherwise causing the member of staff detriment
 - Offering redundancy, ill health early retirement, and/or good references as an inducement for the member of staff to leave this - teaching not only them but their colleagues a lesson

The existence of local policies on whistleblowing and bullying, however good, will not sufficient unless the culture(s) of each organisation is successfully challenged in the same way that the culture of denial will be challenged by the duty of candour.

Role of agencies staff should be able to rely on

Human Resources

77. We welcome the decision by NHS Employers to support the Patients First proposal for a pilot “Early Intervention scheme” to prevent patient care and safety concerns being turned into employment issues. The proposal was made in October 2013, agreed with them in February 2014, but neither party has heard from the DH to whom it was sent, since then.
78. HR has not, however, on the whole, played the positive role that the Code of Professional Conduct that CIPD registrants expects them to. The code is not statutory and large numbers of NHS HR staff appear to not be members. The Mid Staffordshire Public Inquiry Report (2013) contained no recommendations about HR functions. The HR function is almost completely absent from the evidence and from both the 2010 and 2013 Reports other than in respect of whistleblowing. Neither Inquiry asked whether HR specifically, with an eye on the Trust’s duty of care to staff, should have queried the consequences for staff, not least given HR’s stewardship of the staff survey data in respect of staffing levels and care quality. HR staff in Mid Staffordshire allowed a seriously flawed whistleblowing policy to exist throughout 2005-9. There is no evidence at all, throughout that period, of HR seeking to use the evidence of incident reporting, whistleblowing or survey concerns about fear of raising concerns to question the workplace culture. There is no evidence from the inquiry that HR took either a strategic or effective operational approach towards the issue of staff raising concerns or bullying.
79. NHS Employers do provide a range of policies and “tools” for NHS trusts to use to support whistleblowers. It has negotiated agreements with trade unions that are intended to encourage employers to protect whistleblowers. However its own policies and guidance, and evidence to Select Committees, largely fails to acknowledge what Patients First case files, NHS staff surveys, and the research evidence all conclude:
- Detriment for those who raise concerns is not a highly unusual event if the member of staff pursues those concerns that are ignored or not dealt with appropriately
 - A large stable minority of NHS staff are unable to say they have confidence in whether it is safe to raise concerns
 - There is a very sharp difference between the confidence of senior managers and directors in whistleblowing procedures and that of front line staff – something reflected in employers’ evidence

- There is no acknowledgement that there is not a level playing field for those raising concerns and employers because employers are able to cause detriment to such staff but those staff are almost powerless to respond. Once employers respond defensively and ignore the validity of the concerns raised many staff rightly fear detriment. It is rare indeed for a staff member who formally uses their employer's whistleblowing policy to be subsequently promoted. Many suffer health problems as a result of their treatment, many are bullied and significant number find their careers and reputation are at risk.
 - General managers and HR staff are not covered by any statutory professional conduct procedure and almost never suffer any consequences for failure to support whistleblowers or cause them detriment
 - Employees are advised to take legal advice. But whereas the employer has no apparent limit on their costs, whistleblowers must rely on their trade union or insurance company who will normally, cap costs, set a high bar for support for financial reasons, and seek to avoid Tribunals at all if possible, irrespective of whether the original concerns have been addressed. Even if staff gain legal support there may be inordinate delays before any relief is obtained.
 - Clauses in compromise agreements requiring employees to return all documents effectively prevent their further pursuing public interest claims around their original disclosure as does the need for a future reference from their employer.
 - Compromise agreements require employees to not make any derogatory comment about the employer but there is nothing to prevent the employer giving a damaging telephone reference whatever the formal written one states.
 - The original patient care and safety concern repeatedly gets "lost" as the employment dispute takes centre stage.
80. In none of the case files of Patients First have we come across an HR department supporting a whistleblower or preventing detriment to a whistleblower other than in the case (in our thematic review) of an HR Director who was then victimised for his support and his raising concerns about the bullying of staff who themselves raised concerns. In a couple of cases HR staff gave initial informal encouragement to staff to report bullying but no subsequent protection, advice or encouragement to pursue those bullying claims has ever been reported to us. The advice employers receive from lawyers has often sailed "close to the wind" both in their legal advice on how to respond to "unmanageable" whistleblowers (Capsticks) and their proposed Compromise Agreements (Hill Dickinson).

Professional regulators

81. Both the GMC and NMC have issued good guidance for registrants on the importance of raising and escalating concerns. Both acknowledge the fear some staff will have in doing so. Their Code of Ethics and Conduct, Performance and Ethics is weak.
82. In evidence to the Health Select Committee (July 2011), Public Concern at Work shared many of our concerns. They wrote
 - ii. The strongest emphasis for the organisation, GMC or the NMC in and around the reporting of malpractice should be a very hard line on doctors or nurses who have victimised genuine whistleblowers. In our view this should be treated as a disciplinary offence by the trust or an issue of professional misconduct by the professional regulators. This would send out a strong policy message across the NHS that victimisation is taken seriously and whistleblowers will be supported by their professional body. This would be a significant step forward in making it safer to speak up and report poor practice when required.
83. We are aware of “retaliation by referral” and are aware of several cases where such referrals were dismissed by the NMC. We are concerned about reports of doctors dying after GMC referral and are this is currently being reviewed by the GMC. Some of these doctors might well have been raising concerns.
84. Although we appreciate that independent panels decide on fitness to practise cases, we are concerned regulators do not, as a matter of course, screen employer referrals, where there is a prima facie case that the referral follows the registrant raising a concern with their employer. We note Black and Minority Ethnic whistleblowers seem to merit especially poor treatment, including retaliatory referrals, by Trusts. Professional regulators seem to struggle to hold managers to account when they ignore or cause detriment to whistleblowers. In addition, the GMC appear confused about registrants’ misconduct by those exercising managerial roles as in our own referral of the ATOS medical director shows. However, we note the recent NMC case of Jan Harry and acknowledge the NMC’s decision to review managers’ accountability in their current review of their Code.
85. Even when *fitness to practice* panels find no case to answer, the impact of a malicious referral to a regulator has a massive impact upon an individual’s wellbeing, their reputation, and employment prospects.
86. Until recently Patients First was highly critical of the role of the CQC. One of our founders was the first Operations Director of the CQC, David Johnstone, sacked by Cynthia Bower for suggesting the CQC was not “fit for purpose”. Under its new leadership we note a greater willingness to listen. Our impression is that the CQC is

an organisation in transition but its attempt to protect whistleblowers appears serious and sustained. Previously every nurse who raised concerns with the CQC stated the CQC contacted the Trust, were satisfied with the Trust's explanation, and closed down the incident. No nurse recalls the CQC making an unannounced inspection to explore their concerns. We believe this is starting to change and the intelligence gathering the CQC has implemented to trigger an inspection, and its plans to interview whistleblowers, are both helpful.

Professional Body Investigations and College Reviews

87. Professional body advice overlaps with that of professional regulators. For example, the RCGP (2013) recognises that compliance with this ethical requirement

“comes with risks and in some cases those who have “blown the whistle” have suffered severely, in relation to their career prospects and their working environment, despite current policy and process.”

88. Our experience of some professional bodies is disappointing with the exception of the Royal College of Physicians, whose President has called for an Inquiry into whistleblowing. A number of other Royal Colleges have produce advice, some of it good, but their own practice often falls short, notably around the use of Reviews. Royal Colleges should seek to uphold the highest standards and brook no compromise where those standards are at risk. Yet we know of several high profile cases where Royal Colleges have agreed that their peer reviews are "gagged" (Dr David Drew at Walsall), even though that may compromise patient safety or the well being of a whistleblower; or edited or withheld (as happened with the Sibert Report at Great Ormond Street, and at Alder Hey).

Trade unions

89. We repeatedly note that whilst local trade union representatives may try their best, by the time most whistleblowing cases reach a paid trade union officer they have become, in part or whole, an employment issue and most officials seem more comfortable trying to gain some justice or recompense for the member than focussing on the original concern. The best trade union officials and representatives pursue both the interests of the member and the original concerns. But we hear many reports where this does not happen. We repeatedly hear examples of trade unions telling the individual whistleblower that the best course for them is to negotiate an exit from the employer and regularly informing them that the lawyers' advice is that the cost of pursuing any legal claim outweighs any benefits that might be gained.

90. By the time such advice is received the whistleblower is often demoralised, has been, disciplined, suspended or sacked, or can see no future career in that Trust. We have noted cases where a trade union has encouraged staff to drop their concerns in return for disciplinary action being ended against them. Unless their concerns were quickly acted on, their employer's focus became ignoring or discrediting the whistleblower, as described in our paper "the lifecycle of a whistleblower".

Summary

91. The agencies and organisations that have responsibility for patient safety and whistleblowing all seem conflicted, to different degrees, between their narrower organisational interests and that aspect of their mission which should prioritise patient safety.
92. The NHS Constitution (3b) rightly states
- There is an expectation that NHS staff will raise concerns about safety, malpractice or wrong doing at work which may affect patients, the public, other staff or the organisation itself as early as possible.
93. Research evidence makes clear that one precondition for an open, learning culture which staff are encouraged to raise concerns is one in which bullying is not tolerated. Though a culture of fear and bullying were central features of the culture of Mid Staffordshire, the Public Inquiry Report made no recommendation on bullying, none of HR, and no effective ones on whistleblowing other than the end of gagging clauses.
94. Our recommendations seek to help ensure the opportunity is not missed this time round.

Principles: What should be done?

95. Our recommendations are underpinned by:
- our strong support for the principles of openness, transparency and candour;
 - our belief that better staff engagement is crucial to a healthy patient safety culture; and
 - our concern that unless bullying is recognised as a fundamental obstacle to a healthy, learning, compassionate culture, progress will be limited.

96. Research has established the link between how staff are managed, involved, developed and cared for, and a learning, safe and effective health service. Our proposals are underpinned by the powerful evidence that bullying is both the antithesis of staff engagement and is crucial in undermining openness, transparency effective teamwork and candour.
97. Don Berwick set out several helpful “Leadership behaviours that increase risk and make healthcare less safe.” They reflect the research evidence and underpin our recommendations. However culture change cannot be achieved by a list of recommendations alone.
98. Employers and their lawyers have repeatedly sought to emphasise the importance of good procedures and policies and the training of managers and staff to apply them, both in respect of whistleblowing and in respect of bullying. However we agree with those who argue that policies are almost worthless without culture change.
99. Our recommendations draw on our extensive experience, the experiences of the 70 individual whistleblowers who provided their stories and the research evidence. (The research evidence is underpinned by a Background Paper researched from literature about bullying, patient safety and whistleblowing. It contains the full references and background data upon which parts of this submission are based.)
100. Our recommendations are intended to provide immediate support and protection to staff raising concerns as well as helping to foster the wider culture change without which such staff (and the patients that they serve) will forever be at risk.

ANNEX 4: METHODOLOGY

1. As a campaigning organisation which works for change in the NHS and seeks actively to support NHS whistleblowers, Patients First has limited financial and other resources.
2. This submission has been contributed to by three groups of people:
 - members of Patients First;
 - other NHS whistleblowers who have participated in the thematic review by providing details of their experiences;
 - a team who have sought to analyse and distill all the material provided, in the context of available literature and material in the public domain.
3. As noted above, in the main body of this Submission, Patients First has attempted to take great care in providing a reasonably measured and fair view of the materials and analysis reflected in this Submission.
4. The methodology was therefore based on the invitation from Sir Robert Francis QC for people to come forward and tell of their personal experiences of making disclosures in the public interest and share their views and experiences, in order to help inform better practice in the future.
5. It is important to state that a total of 70 health professional responded and provided information about numerous aspects of their experience, mostly in considerable detail. All these were followed up with supplementary questions, although, at the time of writing this submissions, answers have not been received from a number of respondents due to time pressures. Those assisting with reviewing these cases had the advantage that in most cases, input was available from a member of the reviewing Team who knew the case and knew the person concerned.
6. Re-confirmation was sought from all respondents that they were content for their information to be used in this submission, in anonymised form, and general advice about the effect of confidentiality clauses (often imposed in settlements) was provided, noting the risks attendant in allowing use of their information.
7. Against that background, it is intended that it is important for the credibility of Patients First and the Submission to recognise that care has been taken by both the members of Patients First who have contributed stories and the Patients First team working on this

Submission to ensure the reliability of the materials provided to us so that our observations can be based and seen to be based on solid evidence.

8. The methodology adopted in preparing this Submission has been as follows:
 - Material (“Stories”) have been requested from the members of Patients First who are whistleblowers (“Patients First Members”) and others specifically for the purpose of the this Review. Patients First have drawn the attention of Patients First Members to the Review website at www.freedomtospeakup.org.uk so that the scope and purpose of the Review is well understood.
 - The Stories from Patients First Members have been requested primarily through completion of a template questionnaire (“Template”) entitled “Tell Your Story”, below at page 73. Attention is drawn to the introductory comments. The confidentiality of the Stories is vitally important, of course, but Patients First Members are reminded, explicitly, that *“it is important that whatever we publicise can be defended and verified”*. We have sought to construct a process designed (a) to elicit responses – actually getting people to come forward, who might not have done so on their own; (b) to invite candid and targeted observations about their experiences; and (c) to provide, through the patterns of significant numbers, a greater degree of confidence in proper foundation for the observations made.
 - The use of the standardised Template (at page 73 below) was important in terms of trying to categorise different aspects of the narrative and experience of those responding. In some cases the Templates have been completed in considerable detail. In other cases, less so.
9. Patients First operates day to day with a “steering committee” which includes Dr Kim Holt, Ms Jennie Fecitt, and Mr Roger Kline, who together have formed the core of the Patients First team working on this Submission with the considerable assistance of others in the Team, particularly as the scope of work increased beyond what was initially expected. (Members of the Team are listed at Annex 5, on page 75 below.) Since being established, Patients First has sought to support Patients First Members and to understand their stories by meeting with them and talking to them. This has required a commitment of time, travel and energy, but it has enabled Patients First to validate the Stories provided as well as to support the individual Patients First Members. The sheer numbers of Patients First Members and the lack of resource has meant face to face meetings are not always possible, but in general it can be said that a relationship exists in all cases which enables Patients First to understand something substantial about the person as well as the Story.

10. In some cases, particularly those which have been known to Patients First for some time, Patients First understands the case in a lot of detail and is aware of much documentation. It has proved challenging to maintain the depth of knowledge for more recent cases owing to the numbers of them and lack of resource.
11. The purpose of the review of the Stories has been to draw out certain repeat features and characteristics in order to develop a thematic analysis and some valuable conclusions based on a large sample of first hand evidence. Initially, the Stories have been carefully reviewed by the team and contain features or characteristics identified by reference to certain categories. A spreadsheet (“Spreadsheet”) was then prepared and populated which showed which characteristics applied to which Stories. Caution was exercised so as not to exaggerate the application of relevant criteria. Where there was uncertainty as to facts of a story, these were clarified individually. The Patients First Members have expressly consented to the use of the Stories and the information contained in them for the purpose of the Submission.
12. A small number of additional questions were then raised with all of the Patients First Members relating to the use of independent mediation, years of service, time in the relevant job before speaking up and the impact on physical (as opposed to emotional and mental) health and well-being.
13. The information derived from the Stories and the additional questions was then used to populate the Spreadsheet which in turn was considered and analysed for the purposes of drawing up this submission.
14. The Spreadsheet categories used are set out and explained in Appendix.
15. From the information revealed by the Spreadsheet Patients First have sought to identify recurrent themes, patterns of conduct of behaviours, or other recurrent features in the following areas in particular:
 - patient safety concerns
 - barriers and blocks to resolution
 - detriment suffered by the whistleblower.
16. The Patients First team and the Patients First legal team only have shared and discussed the Spreadsheet and the thematic material drawn from it, the draft commentary and analysis, and the draft Submission in its entirety. With the benefit of comments and observations from the Patients First team, the Submission has been finalised by the Patients First legal team.

Template form used for Thematic Review

TELL YOUR STORY

Patients First wants to collate the stories and personal experiences of people who have raised concerns about patient care. We want to know about the problems which have been identified, whether care has been improved as a consequence, and what has been the impact upon and outcome for the whistle blower.

We are collating this information to share with politicians, potentially the media (only with express permission) and the general public more aware of the existence of poor and dangerous care practices, and what happens to people in some organisations as a consequence of having blown the whistle. We want to collate the information anonymously so that individuals cannot be identified unless they have consented to do so. We guarantee that we will protect your identity.

By sharing your experiences of whistleblowing it will help to show how widespread the difficulties are and it will help others to know that they are not alone.

We will contact you by phone / email to ensure the validity of the case, but it will only be designated members of Patients First steering committee who will know the details.

We will need a contact telephone to get back to you so that we can confirm details with you. It is important that whatever we publicise can be defended and verified. We are sure you will understand the reason for this.

Please use the guide notes set out below to tell your story.

Your experience is important. It can be used to bring about change.

We guarantee to keep your identity confidential unless you specify otherwise and we will keep these records safe.

Case number

What did you see or experience that caused you to be concerned?

Were you aware of your employers whistleblowing policy at the time you raised concerns?

What did you do about your concerns? Did you speak to answer yes or no. and when ?

What was the response from those with whom you raised your concerns?

1. Colleagues
2. People in positions of authority
3. Trade union or professional association
4. Political representative e.g. MP
5. Media
6. Other? (If other please specify)

Were any actions taken by the appropriate authority in response to the concerns which you raised?

Please specify here which authority responded and in what way?

Were your concerns resolved? If so when?

Were you kept informed about what was being done in response to the concerns which you raised?

Were you informed about the outcome of any actions taken in response to the concerns you raised? If so, by whom? And over what timescale?

What have been the consequences for you personally and professionally?

1. Are you in a better, worse or no different position as a result of whistle blowing?
2. If your situation is worse because of raising concerns, please give details.
3. Were you at any time offered a severance payment containing confidentiality clauses preventing you from speaking of your experience?
4. If so did you receive full and proper legal advice before the confidentiality clause was offered; in that this is no prevention theoretically to making disclosures in the public interest.
5. Were you aware of DH guidance regarding the use of confidentiality clauses?

Would you do the same again given your experience?

Would you advise others to do what you have done?

Is there anything you would do differently?

Please give your name and contact details so that a representative from Patients First can speak to you in the strictest confidence.

We can record these separately if you wish .

ANNEX 5: TEAM

17. The Team which has worked on this submission and put it together over the last two months has had the benefit of the input from all those respondents (not all of them members of Patients First) who were prepared to tell their stories and provide their insights. The Team that has produced this Submission comprises:

Dr Kim Holt	Steering Committee of Patients First Consultant Paediatrician at University of Manchester 1984. Trained in paediatrics in London and Manchester and Consultant since mid 90s. Whistleblower in the Baby P case. Masters in Community Child Health and founded Patients First and has since worked for the CQC. Her interests are social paediatric and child protection. She campaigns for social justice.
Ms Jennie Fecitt	Steering Committee of Patients First RN, BSc (Hons) Specialist Practitioner Adult Nursing, INMP, PGCE Lead Nurse (UK) for Patients First and whistleblower in a well-known legal case. Having spent many years as a senior nurse in Emergency & Unscheduled Care Services, now Managing Director for Primary Care Training Services and provides mandatory training to healthcare professionals across the NHS and private healthcare sector. Registered Nurse Panelist for the Nursing, Midwifery Council, Fitness to Practice Conduct and Competency & Health Committees and is an Honorary Lecturer at the University of Manchester.
Mr Roger Kline	Steering Committee of Patients First Roger Kline is Research Fellow at Middlesex University Business School. He is co-author of Professional Accountability in Social Care and Health (2012), The Duty of Care (2013) and has written extensively on workplace culture including on race discrimination, most recently in The Snowy White Peaks of the NHS (2014).
Clive Lampard	Practising solicitor and qualified mediator. Clive was educated at London University and Nottingham Law School, qualified at Slaughter and May and practised at Macfarlanes where he was a partner from 1991 to 2011. Clive has an interest in the resolution of whistleblowing conflict and is presently studying for an LLM at Queen Mary College.
Frances Bennett	Law graduate of LSE with a strong interest in Medical Law and bioethics. She currently works at Compassion in Dying, a charity helping people to know and use their rights at the end of life.
Simone Davies	Law graduate, who graduated from the LSE in 2014
Chloe Campbell	Barrister at Henderson Chambers
Patrick Green QC	Barrister at Henderson Chambers

ANNEX 6: EARLY INTERVENTION SCHEME

Patients First

14th November 2013.

Dear Caroline

Protecting Patient Safety and Care Concerns - an early Intervention Scheme Pilot

We have given careful thought to the idea of a pilot to test an early intervention approach to whistleblowing in the healthcare service. Below are our detailed albeit preliminary thoughts for your review. We would be grateful to hear from you so that we may agree the next steps to fully scope the idea.

1. The purpose

The Mid Staffs Public inquiry and the subsequent Francis report, Berwick review and Clwyd report have highlighted how we cannot allow concerns about patient care to become bogged down in internal disagreements, and how the current legislation and systems are not working.

It is now generally acknowledged that whistleblowers in the health service too often place themselves at personal and professional risk, and this proposal is to try and “nip in the bud” and address early the patient safety issues that are raised, with an opportunity for external expert oversight, and with some additional support for the individual or team concerned.

This proposal is intended ensure that serious patient safety and care concerns are dealt with fairly and expeditiously and without detriment to the person(s) raising them. Further to prevent disputes arising and for issues becoming entrenched. Thus it is seen to be an effective tool to encourage constructive dialogue at an early stage and prevent patient safety being further compromised. We believe early intervention is key.

2. The benefits

The scheme is intended to prevent patient safety and care concerns being turned into protracted employment disputes with the whistleblowers suffering victimisation and detriment and the concerns being sidelined. Where that happens it is damaging and

impedes the development of a learning culture, damages staff and leaves safety and care concerns unresolved.

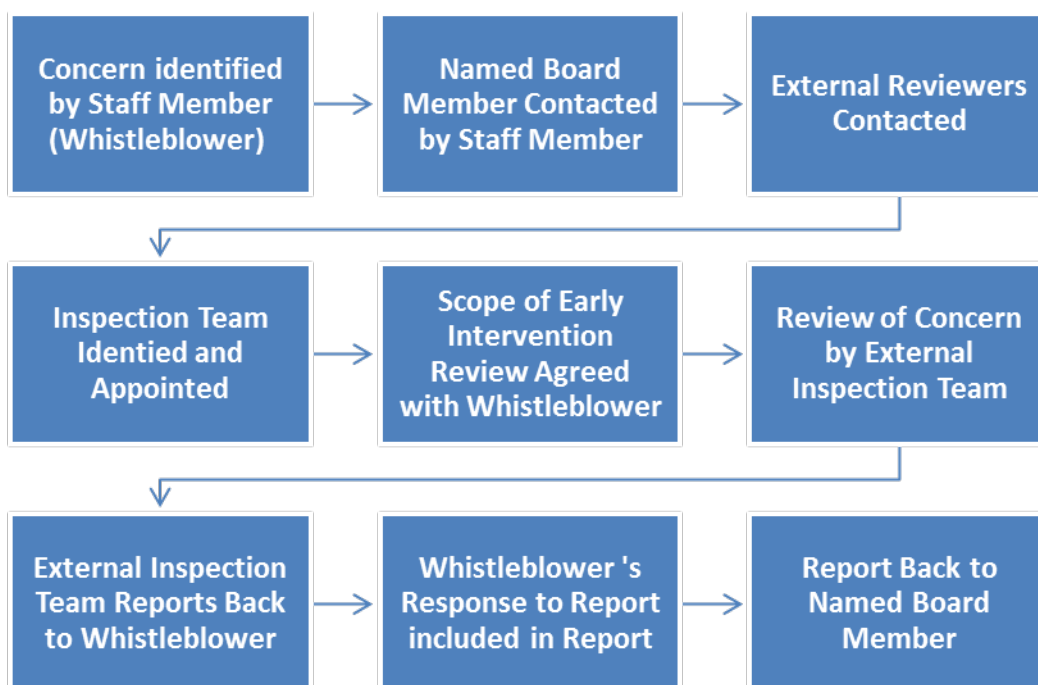
Specific benefits include:

- Immediate identification of and thus speedier resolution of patient care and safety concerns
- Protection for whistleblowers
- Less loss of staff resources due to a reduction in ill health and suspension costs
- Greater encouragement of staff to raise concerns
- Reduced litigation costs
- A better and improved learning culture

3. The proposal in outline

We would like to explore with NHS Employers and the DH an “early intervention” approach which would seek to secure attention to the concerns raised whilst eliminating the risks to whistleblowers.

In reflecting on this flow chart please note the threshold a “concern” would need to met to fall within this scheme



We suggest (but not exclusively) the following parameters:

- a. At the heart of the proposal is an amendment to local whistleblowing procedures which subject to a threshold being reached would give staff the option of accessing external early intervention
- b. The threshold would be that the concern being raised either reached or might reasonably be considered to have reached the criteria required to trigger a PIDA claim ie a criminal offence, failure to comply with legal obligations including the duty of care, health and safety risk, and information about these issues has been or is about to be, concealed. There would be no "good faith" test since it is the patient safety and care we are concerned to protect. There might be exceptional circumstances where the threshold was triggered in grievances and disciplinary processes where staff (or management) had not originally realised the seriousness of concerns that had been raised.
- c. Immediately, if the threshold is reached, staff would have the option of accessing external early intervention
- d. The external intervention would involve persons with appropriate expert specialist knowledge from outside the Trust, in liaison with the named Board member with lead responsibility for patient safety (see below) conducting a swift and early preliminary investigation, with access to documents and witnesses they require, to determine if there is prima facie evidence that the concern can be substantiated. If this is the case, a report will be provided to the Trust and the individual(s) concerned to give them one week for comments and a final report should be provided in no more than one calendar month from the initial complaint being raised. Careful consideration would need to be given to ensuring that the external intervention was one the whistleblower and the trust were agreeable to.
- e. Each Trust in the pilot will have identified a Board member with specific named responsibility for patient safety. That person will have responsibility for ensuring that the preliminary findings of the investigation are acted upon. They may, as necessary, request a more detailed investigation from the same team, or refer the matter to CQC for further investigation. Every time an investigation is commissioned the CQC and the Board will be notified at the commencement, and upon completion they will be provided with a copy of the report.
- f. Should the report uphold in whole or in part the concerns raised then the person(s) raising those concerns will be notified in a timely manner of follow up action.
- g. The name of any person whose concerns trigger such an early intervention report will be provided to the CQC and they may then be one of the persons interviewed subsequently by the CQC when interviewing whistleblowers as part of any inspection.
- h. We should take further advice from one or two patient safety leaders as to how to make these proposals part of a wider move towards an improved culture - we would suggest Dr Umesh Prahbu, David Dalton and one of the patient ombudswomen (Delilah Hesling or Helene Donnelly) We should also consult closely

with the CQC to explore overlaps with their function and to see whether this might assist the CQC in their revised modus operandi.

- i. We should ensure that in some form of patient involvement in the pilot schemes either directly or in monitoring their progress and outcomes informed by the expertise of James Titcombe (CQC), Julie Bailey, and National Voices.
- j. The pilot scheme might also explore other means of underpinning the importance of a learning culture by introducing values based criteria for interviews for all Board members, specifically around their past experience of whistleblowing.
- k. It would be essential that the professional regulators (GMC, NMC, and HCPC) were consulted and their commitment to supporting the scheme in its pilot form was sought. Specific discussions should be held with each regulator to prevent inappropriate referrals to regulators which might reasonably be seen as arising from relation for raising concerns rather than genuine concerns about safety and conduct. Similar discussions might be needed with NCAS.
- l. It would be expected that as a consequence of this scheme, suspension of staff raising concerns would either cease or have to be justified by overwhelming evidence it was necessary

4. Operational issues

We would need to agree:

- A smaller number of Trusts to pilot the scheme
- A time period sufficient to test the approach but not so long as to delay its wider implementation if successful
- Some form of effective, agreed, analysis of its impact, benefits and costs
- Preliminary training and support - who by and to what extent, to ensure staff, unions and senior management are on board and understood the process
- A baseline audit prior to commencement
- The implications of the final government response to the Francis report
- That if the scheme was agreed in principle that its implementation would be expedited, subject to adequate preparation
- The precise relationship with the CQC

This proposal would not affect any current staff entitlement to pursue such concerns in other ways including protecting their Tribunal claims though it might be that the scheme would reduce the necessity for such claims which currently primarily arise from victimisation and detriment suffered by those who do raise concerns.

Yours sincerely

Dr Kim Holt (chairperson)

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