Submission to the Whistleblowing Commission

Patients First

June 2013
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The purpose of this Briefing

Patients First is a network of NHS whistleblowers who purpose is to reduce death and harm in the NHS by campaigning for the UK Government to create policies and laws that ensure the NHS becomes open and accountable and we will actively support all those who raise concerns about patient safety.

We seek to support NHS whistleblowers and help create a work environment where all staff feel able to raise concerns freely without fear of detriment so there is no need for individuals to find the courage to raise concerns.

This response to the Whistleblowing Commission’s call for evidence brings together both publicly available information and research, and lessons drawn from our own experience.

June 2013.
Executive summary

This submission brings together publicly available information and research, and lessons drawn from our own experience. Further supplementary examples drawn from our recently initiated library of case studies will follow.

At the heart of our concerns about the effectiveness and protection of whistleblowers in the NHS lie wider concerns about the culture which is frequently fails to learn the evidence base around patient safety, good management and the link between the treatment of staff and the care of patients.

Whistleblowers in the NHS whose concerns and alerts are not acknowledged and acted on at an early stage frequently find themselves as the focus on investigation with the widely reported consequence that large numbers of staff are concerned about the potential consequences for career and even livelihood of raising public interest concerns.

The failure, on the whole, of NHS Boards, senior managers, regulators of services and of professions, and trade unions to acknowledge and promote the positive role of whistleblowers is mirrored by the frequently dismissive approach to patient complaints. Mid Staffordshire should have been a wakeup call, and in some Trusts it has been. But overall, the NHS culture is not yet sufficiently supportive of openness, transparency, candour and accountability primarily due to a failure to challenge the bullying culture so pervasive in the service.

We welcome any strengthening of the law but in the NHS it is the bullying culture above all which must change not only for the benefit of whistleblowers but of patient safety and patient care.

June 2013.
1. The preconditions for a safe, good quality NHS

The preconditions for a safe, good quality NHS include an environment in which:

- **staff can raise concerns**, their doing so is welcomed and expected, and the organisation learns from them as long as they are made in good faith (*Wachter, R. Understanding Patient Safety. 2012*)
- **patients can raise concerns and complaints** and they are welcomed and seen as learning opportunities. (*Francis (2013). Kings Fund: Patient-centred leadership. Rediscovering our purpose. 2013*)
- **the organisation has an open, transparent “just” culture** in which mistakes and problems are seen as learning opportunities with the focus on future prevention and all data except confidential patient data is openly shared (*Francis 2013*)
- **management and leadership is distributed and facilitative**, rather than bullying and top down (*Beverly Alimo-Metcalfe. Engaging boards The relationship between governance and leadership, and improving the quality and safety of patient care (2012)*
- **a “human factors” approach influences the entire organisation** (See the work of the Health Foundation and the Clinical Human Factors Group)
- **staff are cared for and valued, so they better care for patients and themselves** (*West, M. and Dawson, J. Employee engagement and NHS performance. Kings Fund 2012*)
- **compassion is valued as an indispensible part of good care** (*NHS Confederation: Compassion in healthcare. The missing dimension of healthcare reform? 2008 and DH. Compassion in practice – nursing, midwifery and care staff – our vision and strategy 2012*)
2. To what extent are these conditions are met?

The Mid Staffordshire Inquiries’ reports demonstrated the extent to which these preconditions were not met in one individual Trust, and the consequences that flowed from that.

The evidence from numerous NHS staff surveys and our own experience as Patients First is that a large number of staff are fearful of the consequences of raising concerns and that there have been, and still are, are tremendous pressures on staff and managers to collude in a target driven, bullying culture in which financial risk takes priority over clinical risk, in the way Robert Francis so eloquently describes in Mid Staffordshire.

a. Bullying is widespread

Robert Francis QC repeatedly referred to bullying as a key driver of the toxic culture at Mid Staffordshire hospital - yet made not a single recommendation about stopping it. Bullying was not mentioned in the Government’s response to the Francis Report. He states that “an explanation for staff’s reluctance to come forward with concerns was that they were scared” (Francis: Vol 1. B. 37. 2010). Witnesses described “an “endemic culture” of bullying” (Francis: Vol 1. B. 38 2010) with graphic examples of the victimisation of those who did raise concerns (Francis. Vol 1. 2.374 - 2.397. 2013).

The Mid Staffordshire NHS Trust Public Inquiry considered research commissioned in 2007 by the Department of Health from three respected US organisations which had interviewed some 50 very senior NHS stakeholders. The research was not originally published but was released following an FoI request in 2010. One concluded that a "pervasive culture of fear in the NHS and certain elements of the Department for Health" existed throughout the NHS and in parts of the DH, with fear among chief executives of public humiliation or losing their jobs as a prime driver for quality improvement” and that “the NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement.”


These reports were largely dismissed by the Department of Health witnesses to the Mid Staffordshire Public Inquiry as “caricatures.” Sir David Nicholson told the inquiry that:

“he didn’t believe the JCI report was significant. Indeed, in general, the department witnesses did not accept or even recognise some of the criticisms
contained in the American reports, and yet many of those criticisms of a top-down and bullying culture were described by witnesses to the inquiry.”


In 2009, Sir Ian Kennedy, the departing chair of the Healthcare Commission (now CQC), warned about the “corrosive” impact of bullying among NHS staff. He said bullying worried him “more than anything else” in the NHS and was “permeating the delivery of care”. Sir Ian said bullying was “one of the biggest untalked about problems in the delivery of good care to patients”. (Charlotte Santry, Bullying ‘permeating’ patient care, warns Healthcare Commission. HSJ. (1 April, 2009).

The 2008 NHS staff survey which prompted his remarks showed that 12% of staff said they had suffered bullying, harassment or abuse at work by colleagues in the previous year. It is much higher than elsewhere in employment. For example, the last comprehensive survey of UK employees in the same year reported just 7% had been bullied or harassed in the previous two years. (Fevre, R. Nichols, T. Prior, G. Rutherford, I. Fair Treatment at Work Report: Findings from the 2008 survey. Employment Relations Research Series No.103. September 2009)

The 2012 NHS staff survey reported that the proportion of staff reporting bullying by colleagues and managers had doubled in just four years. In 2012, 24% (almost one quarter) of staff reported they had experienced bullying, harassment or abuse from either their line manager or other colleagues. 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% now.

In 2007 the NHS Confederation identified bullying of managers as a significant problem stating there was also a 'culture within the NHS which encourages bullying, and this stifles leadership potential'. The report said bullying came in the form of 'direct threats, described as 'insultingly brutal' by one external observer, and 'distressingly macho' by another.' Leaders claim bullies thrive and middle managers are left to fail (Helen Mooney: Leaders claim bullies thrive and middle managers are left to fail. HSJ. 21 June, 2007)

Two years later 2009 NHS Confederation (employers) survey described a “culture of blame”. It reported that “several of our interviewees identified a problem of a perceived or real toxicity in the wider system inhabited by chief executives, describing the environment as 'brutal', 'arbitrary', 'prone to favouritism' and intolerant of risk-taking
that isn’t successful.” (Rebecca Evans. NHS is a 'brutal' place for its leaders. HSJ. 5th March 2009)

A November 2012 survey of 81 NHS chief executives suggested that the culture of fear reported to Lord Darzi in 2008 pervades the NHS right from the top. Many respondents describe a "bullying culture". Another respondent said: "A climate of fear pervades the NHS, driven by ruthless governance and accountability regimes that have little interest in achieving anything other than the avoidance of blame.” Another added: “The fear of speaking out is worse than I’ve known it in over 32 years in the NHS.” 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.”

http://www.hsj.co.uk/news/nhs-chief-executives-highlight-climate-of-fear/5051985.article

Every NHS employer has policies making bullying a disciplinary offence. Yet they are largely ignored and often not even understood. Bullying is not specifically defined in law, but in their advice leaflet for employees, the statutory body Acas give the following definition: “Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient.” There is no national data collection or analysis within the NHS other than the annual NHS staff survey. In the experience of Patients First it is extremely rare for a bullying complaint to be upheld.

Bullying affects doctors as much as other professions. 24% of medical consultants reported they were bullied in the 2012 NHS staff survey. 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." (15 October 2012) Barriers to whistleblowing in the NHS. Editorial. BMJ 2012; 345 doi: http://dx.doi.org/10.1136/bmj.e6840 (Published 9 October 2012)

http://www.bmj.com/content/345/bmj.e6840/rr/608555
b. The 2012 NHS staff survey.

The 2012 NHS staff survey showed some very limited improvement in some of the staff responses regarding their treatment at work, but there remain serious concerns that inevitably impact on patient safety and care and on staff well being. These include:

- **Appraisals.** There continues to be an improvement in the proportion of staff receiving appraisals, up from 80% in the 2011 survey to 83% in 2012, however only 36% of staff said these appraisals were well structured.

- **Is work valued?** Only 40% of all staff were satisfied with the extent to which they felt that their trust values their work, this figure is lowest for ambulance staff (23%)

- **Management communication.** Just over one third of staff felt that communication between managers and staff is effective and just over a quarter (26%) reported that senior managers act on feedback from staff.

- **Attending work whilst ill.** Sixty-nine percent of staff reported that they had attended work in the previous three months despite not feeling well enough to perform duties (up from 65% in 2011).

- **Work related stress.** Thirty-eight percent of NHS staff overall reported during the last 12 months they have felt unwell as a result of work related stress.

- **Reporting of errors, near misses and incidents** Overall, eighty-six percent of all staff felt encouraged by their organisation to report errors, near misses and incidents (compared with 83% in 2011). Only 14% of all staff felt that reporting of errors would lead to punishment or blaming of those involved. Sixty-three percent of staff felt that incident reporting was handled confidentially, while 61% (up from 57% in 2011) thought that action was taken to prevent similar errors occurring in the future. The percentage of staff who felt informed about (42%, 37% in 2011), or given feedback on changes made as a result of errors, near misses and incidents remains low (42%, 38% in 2011), with only a slight improvement on 2011.

- **Safety when raising concerns.** Although the majority of NHS staff would know how to report any concerns they have about fraud, malpractice or wrongdoing (90%), just 72% would feel safe raising these concerns and only just over half (55%) would feel confident that their organisation would address them. 28% were unable to say they felt safe raising such concerns.

Most worrying of all were two sets of response which directly reflect concerns at Mid Staffordshire.
• Under a third of staff (30%) feel that there are **enough staff to enable them to do their jobs properly**. As the budgetary pressures on the NHS increase (they already have in the 12 months since this survey) this is an extremely alarming figure which inevitably encourages bullying and leads to stress at work and both impact on patient care and safety;

• **The proportion of staff witnessing potentially harmful errors, near misses or incidents** in last month was unchanged since 12 months previously at 32%. However, **the proportion of staff reporting errors, near misses or incidents witnessed in the last month fell by 6% (100,000 incidents)**. It is difficult to explain how this is possible unless it is cross referenced to the data on bullying, staffing and the significant numbers of staff who do not feel safe reporting concerns.


c. **There is a widespread perception – extending to student professionals – that raising concerns can be dangerous**

A decade ago following the Bristol Royal Infirmary Inquiry, Professor Ian Kennedy recognised the fear that prevents staff raising concerns or challenging superiors.

"There is a real fear among junior staff (particularly among junior doctors and nurses) that to comment on colleagues, particularly consultants, is to endanger their future work prospects. The junior needs a reference and a recommendation; nurses want to keep their jobs. This is a powerful motive for keeping quiet."

http://www.bristol-inquiry.org.uk/

That the Inquiry took place at all was due to the courage of whistleblower Dr Steve Bolsin. In 1989, consultant anaesthetist Dr Bolsin identified that too many babies were dying during heart surgery at Bristol Royal Infirmary. Over the next six years he attempted to improve the service and cut mortality rates for children’s heart surgery in Bristol from 30% to under 5%. This resulted in his being victimised by his paediatric cardiac surgeon colleagues. When the hospital management refused to investigate, he became a public interest whistleblower. Though his actions led to the Kennedy Report, he himself had to move to Australia, where he has remained as an eminent anaesthetist and expert on patient safety http://news.bbc.co.uk/1/hi/health/532006.stm
A 2009 Royal College of Nursing survey reported that some 78% of staff believed they would be victimised or their career would suffer if they reported any concerns to their employers. Of those who had reported concerns, only 24% said their employers had taken immediate action and 35% said no action was taken at all.

(http://www.rcn.org.uk/newsevents/news/article/uk/rcn_launches_phone_line_to_support_whistleblowing_nurses)

Also in 2009, a BMA survey reported that of those who had raised concerns with their Trust, 46 percent had no idea whether anything happened as a result. 16 percent said they had been warned that raising concerns could adversely affect their employment. Where doctors had not raised concerns, the most common reason was that they were not confident that it would make a difference. The survey reported “that more than half of doctors surveyed had concerns about standards of patient care in their workplace, and some of those who reported their concerns agreed that ‘The trust indicated to me that, by speaking up on sensitive issues, my employment could be negatively affected.” BMA survey. Speaking up for patients. Final report. BMA Health Policy and Economic Research Unit, 2009 http://www.bma.org.uk/images/speakingupforpatientsmay2009_tcm41-186796.doc

A linked study of whistleblowing policies from 118 trusts found many was overly cautious and negative, with some making excessive use of words such as “disciplinary” with little emphasis on staff right to go to outside bodies with concerns.

It concluded that:

"We need some positive recognition for people who have raised concerns. They shouldn't be treated as troublemakers, ostracising them, suspending them from work and so on."

(Changing the face of whistleblowing BMJ 2009;338:b2090)

The 2011 survey of 3,000 members of the Royal College of Nursing found:

nurses were more reluctant to report concerns and managers were less likely to act on them than in a similar survey conducted two years ago.

More than 80 per cent of those who responded said they had raised concerns about staffing levels or similar issues affecting patient safety but in almost half of cases no action was taken.
More than a third of nurses said they had been discouraged from complaining (up from a fifth in 2009) and only a third felt confident their employers would protect them (down from almost half)

(Jeremy Laurance NHS whistleblowing safeguards not working Independent Monday 05 December 2011)

In 2013 the RCN polled its members and despite the 2010 Francis Report three years previously, 24% said they had been discouraged or warned off and 45% said their employer took no action after they had spoken out. The RCN union said the findings showed there was an NHS "culture of fear". (BBC News. 23 April 2013 Nurses 'warned off whistle-blowing in culture of fear')

Things appear no better in Scotland where 60% of nurses said they believed that better support is needed for whistleblowers, according to an ICM survey (April 2013) conducted for the RCN which also revealed that only 30% of those surveyed believe their workplace has a good culture, where staff are listened to and concerns acted upon.

https://www.rcn.org.uk/newsevents/news/article/scotland/better_support_is_needed_for_whistleblowers,_say_60_of_nurses_in_scotland

The month previously, GPs in Scotland called for a "culture change" in the NHS to make it easier for clinicians to raise concerns about patient safety.

Dundee GP Andrew Cowie told the BMA Scottish local medical committees conference, that clinicians who tried to bring up these issues were too often treated as ‘irritants’, seen as troublemakers, and were bullied to ensure their silence.

He added:

‘In practice, clinicians raising concerns are too often treated as irritants. Frontline workers are all too often dissuaded — through learnt helplessness after being ignored, over and over; by being saddled with the responsibility to solve any problems they raise themselves; or, at worst, by covert measures of even bullying to silence “trouble-making” clinicians.’


A 2012 survey of doctors by the Medical Protection Society reported
• 53% of respondents stated they had seen incidences of concern that they wish they’d done more to address.

• Only 11% of respondents said they would be confident of the process if they blew the whistle.

• 49% of doctors said ‘fear of consequences’ is why the whistleblowing process is ineffective.

• 60% of respondents would consider not blowing the whistle, even if they thought they should, because of doubts about the process.

• Less than 40% of doctors who had raised concerns felt they had been addressed.

• Only 33% of doctors who had blown the whistle said that colleagues supported their decision.

• 18% of those who had blown the whistle felt isolated as a result; 14% moved location/jobs; and 12% suffered health issues.

• The ‘fear of consequences’ is the most common reason doctors feel the process for raising concerns is ineffective and many also experience a lack of support from their organisation.

• All NHS organisations are required to have a whistleblowing policy, yet our survey reveals that many doctors experience difficulties in following them. Nearly 90% of doctors surveyed were unsure or had no confidence in whistleblowing processes and more than half of doctors would consider not raising a concern because of doubts about the process.

• The ‘fear of consequences’ is the most common reason doctors feel the process for raising concerns is ineffective

The MPS survey noted that

“All doctors need to be supported to speak up, but none more so than junior doctors who will shape the hospitals and practices of tomorrow. MPS has been involved in cases where the careers of junior doctors have been derailed as a direct result of raising concerns about patient safety.”

http://www.medicalprotection.org/uk/check-up-autumn-2012/whistleblowing/doctors-afraid-to-speak-out

A 2007 survey of junior doctors by the Postgraduate Medical Education and Training Board found half of trainees in non-foundation posts who reported being bullied said it came from consultants. (Charlotte Santry. Bullying: the ‘corrosive’ problem the NHS must address HSJ. 23 April 2009)
Those concerns about junior doctors are reflected in the results from a Nursing Times survey after the Francis report was published. It found that when student nurses were asked “What do you feel are your biggest barriers to raising concerns about a health professional’s practice or attitude while on placement? (Tick all that apply)” they responded as follows (%):

<table>
<thead>
<tr>
<th>Barrier</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat of bullying by colleagues</td>
<td>56.4</td>
</tr>
<tr>
<td>Lack of standard procedures for raising concerns</td>
<td>26.9</td>
</tr>
<tr>
<td>Potential failure of my placement to act on my concerns</td>
<td>54.3</td>
</tr>
<tr>
<td>Potential failure of my university to act on my concerns</td>
<td>26.2</td>
</tr>
<tr>
<td>Risk of being viewed as a troublemaker by my placement</td>
<td>76.4</td>
</tr>
<tr>
<td>Worries about failing my placement or not getting all my paperwork signed off</td>
<td>72</td>
</tr>
</tbody>
</table>

(Steve Ford Full survey results: are student nurses safe to speak out? Nursing Times. 18 April, 2013)

A survey by Nursing Times of employed nurses asked a similar question:

“what are the biggest barriers to raising concerns about a colleague's practice or attitude where you work?” to which nurses responded as follows (%):

<table>
<thead>
<tr>
<th>Barrier</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of standard procedures for raising concerns where I work</td>
<td>3.7</td>
</tr>
<tr>
<td>Failure to act on concerns by line managers</td>
<td>24.0</td>
</tr>
<tr>
<td>Failure to act on concerns by senior managers</td>
<td>16.4</td>
</tr>
<tr>
<td>Risk of being viewed as troublemaker by employer</td>
<td>27.6</td>
</tr>
<tr>
<td>Threat of bullying by colleagues</td>
<td>15.5</td>
</tr>
<tr>
<td>There are no barriers to raising concerns where I work</td>
<td>12.8</td>
</tr>
<tr>
<td>There are no barriers to raising concerns on my placement</td>
<td>6.6</td>
</tr>
</tbody>
</table>

(Full survey results: are you safe to speak out? 5 March, 2013. By Steve Ford. Nursing Times.)

Such findings echo research undertaken prior to the 2010 Francis report which expressed similar concerns on behalf of nurses.
Reprisal for whistleblowing remains a major concern for nurses. Future research should concentrate on developing an environment where nurses feel able to report incidents safely. Confidentiality should be given priority, thereby reducing the fear of reprisal or future repercussions”


Research for the NMC in 2010 found the fear of being victimised after blowing the whistle is a major barrier to nurses and midwives reporting problems. The NMC surveyed 56 organisations and 395 nurses. Many expressed fears about the implications for individuals of raising concerns, particularly the risk of victimisation, being stigmatised as a “troublemaker”, bullying or intimidation. The research was commissioned as part of a consultation on draft guidance for raising and escalating concerns. Roughly two thirds thought someone following the draft guidance would still face barriers (Ben Clover. Fear of victimisation stops nurses whistleblowing, says NMC research Nursing Times. 10 August 2010)

Public Concern at Work, the independent whistleblowing charity which used to run the NHS whistleblowing helpline until 2012 published Whistleblowing: the inside story with the University of Greenwich (Work and Employment Relations Unit) in 2013 which analyses the experiences of 1,000 whistleblowers. It reported in a cross sectoral analysis, the only one of its kind in the UK:

- 83% of workers blow the whistle at least twice, usually internally.
- 15% of whistleblowers raise a concern externally.
- 74% of whistleblowers say nothing is done about the wrongdoing.
- 60% of whistleblowers receive no response from management, either negative or positive.
- The most likely response is formal action (disciplinary or demotion) (19%).
- 15% of whistleblowers are dismissed.
- Senior whistleblowers are more likely to be dismissed.
- Newer employees are most likely to blow the whistle (39% have less than two years' service).

The report says “The report follows the whistleblower’s journey, starting with the type of concern they have, the reactions they expect and experience from colleagues and managers, through to when they call for advice. This journey is
often fraught with threats, fears and contradictions, and can be incredibly stressful for the individual involved. “

**Profile of a whistleblower:** The evidence from this research shows 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.

**Two chances for employers:** Employers have up to two opportunities to listen to staff as the concern is usually raised at most twice with line then middle management.

**Institutional silence:** Whistleblowers are most likely to experience no response from management either to them personally or to the concern that has been raised.

**Reprisal short of dismissal:** Despite dismissal being the most feared response, the most common response is formal reprisal, e.g. written warning or disciplinary. This could be due to a fear of litigation, showing that the law is at least in part working. However, more must be done to protect workers before dismissal.

**Seniority matters:** Staff on a more junior level are more likely to be ignored than those in senior positions, who are more likely to be dismissed.

**Persistence required but carries risk:** For the few who raise a concern a third or fourth time it is at this point it becomes more likely that the matter will be addressed but also more likely that the whistleblower will be dismissed or subjected to reprisal.

**Oversight matters:** those who raise a concern with a regulator have better outcomes.

**Organisations are better at handling wrongdoing than whistleblowers:** in half of the cases where final outcomes were available the wrongdoing had been stopped but most individuals were still struggling on some level.

The **House of Commons Health Select Committee**, 2011 acknowledged such fears in stating
Doctors and other practitioners who have raised concerns [about] other staff have sometimes been subject to suspension, dismissal or other sanctions. The committee therefore intends to examine this issue in more detail in due course. 


The link between bullying and whistleblowing has been understood for a long time:

The greatest fear is that of reprisals from the employer, associates of the bully, and powerful professionals, who may close ranks and compromise the career of the whistle blower

Field T, Becker K, Mackenzie GM, and Crossan L. Bullying in medicine. BMJ. 2002; 324: 786.

As NHS Employers put it.

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 ‘Trust and culture change are essential to tackle bullying’ Nursing Times. 12 July, 2011

In his second report Robert Francis considers in detail the experience of whistleblowers at Mid Staffordshire NHS Trust. (Francis, R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1. Paras 2.371. to 2.400). We recognise the patterns of treatment so eloquently described there. In Chapter 6 below we consider a number of examples of the victimisation of whistleblowers from our own experience.
3. What are the key problems with the culture in many NHS trusts?

In his 2010 First Inquiry Report (Francis 2013. Para 45 Executive summary) Robert Francis states:

"The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff. A number of factors contributed to this:

- **attitudes of patients and staff** – patients’ attitudes were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff. Although some members of staff were singled out for praise by patients, concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors.
- **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.
- **low staff morale** – the constant strain of financial difficulties, staff cuts and difficulties in delivering an acceptable standard of care took its toll on morale and was reflected by absence and sickness rates in particular areas.
- **isolation** – there is a sense that the Trust and its staff carried on much of its work in isolation from the wider NHS community. It was not as open to outside influences and changes in practice as would have been the case in other places and lacked strong associations with neighbouring organisations.
- **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.

- **acceptance of poor standards of conduct** – evidence suggests that there was an unwillingness to use governance and disciplinary procedures to tackle poor performance. The Inquiry has heard of particular incidents of apparent misconduct which were not dealt with appropriately, promptly or fairly.

- **reliance on external assessments** – The evidence indicates that the Trust was more willing to rely on favourable external assessments of its performance rather than on internal assessment. On the other hand when unfavourable external information was received, such as concerning mortality statistics, there was an undue acceptance of procedural explanations.

- **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.”

Elsewhere he described the performance culture in which front line staff felt forced to prioritise targets over patient welfare for fear of victimization and job loss (Francis, 2010 paragraph 63), and which incentivised short cuts and “unacceptable standards of performance” (Francis, 2013: paragraph 1.111).

The report concludes that excessive workloads, inappropriate skill mix, a bullying culture, and the prioritisation of finance over healthcare contributed to the normalisation of appalling treatment. It states “an explanation for staff’s reluctance to come forward with concerns was that they were scared” (Francis: Vol 1. B. 37. 2010). Witnesses described “an "endemic culture" of bullying” (Francis: Vol 1. B. 38 2010) with graphic examples of the victimisation of those who did raise concerns (Francis. Vol 1. 2.374, 2.397. 2013).

A culture existed of ‘gaming’ targets such as waiting times, discharges, and incident (and even mortality) reporting. This culture led to a fundamentally misplaced prioritisation of financial risk over clinical risk and quality of care in which, as the NHS chief executive Sir David Nicholson put it, “quality wasn’t the organising principle of the NHS, it wasn’t the thing that was driving us during that period”. (Evidence 28th September 2011. http://www.midstaffspublicinquiry.com/sites/default/files/transcripts/Tuesday_27_September_2011_-_transcript.pdf)

In every significant respect Mid Staffordshire Foundation Trust got it wrong. Research shows that managers under pressure to deliver on targets typically default to a
command and control style, become insensitive and defensive, putting a downward pressure on quality of care (Alimo-Metcalfe, Engaging boards The relationship between governance and leadership, and improving the quality and safety of patient care. Beverly Alimo-Metcalfe (2012). The trust did the opposite.

Research has shown that patient experience and perhaps, most crucially, clinical outcomes including patient mortality, infection rates, speed of recovery and discharge, are directly linked to levels of staff “engagement” and satisfaction. Staff who are cared for provide better care. (West, op cit 2012). The Trust did the opposite.

Research looking into patient safety (Liam Donaldson An organisation with a memory. (2000) DH; Robert Wachter. Understanding Patient Safety (2008). Donald Berwick. Improvement, trust, and the healthcare workforce. BMJ Quality and Safety. http://qualitysafety.bmj.com/content/12/suppl_1/i2.abstract and the ongoing work of the DH Clinical Human Factors Group Factors) has been influential in moving the NHS away from a “blame” culture to one which recognises that human error is inevitable in a highly complex field like medicine and that that the impact of human error culture amongst front line staff. The Trust did the opposite.

Comprehensive research funded by the Department of Health concluded that strong links between staff ‘engagement’ and clinical outcomes (through well-structured appraisals, a well-structured team environment with clear goals, a supportive line management, good training, learning and development) are all good predictors of patient satisfaction, patient mortality and staff absenteeism and turnover. (Michael West and Jeremy Dawson. NHS Staff Management and Health Service Quality. Aston Business School, 2011. http://bit.ly/o225O2). The Trust did the opposite.

Management research within the NHS demonstrated that the messages middle managers received from their senior managers were ones of ‘transactional change’ ie direct pressure relating to targets and performance, whereas the messages that the managers wanted to hear were those of ‘transformational change’ ie “do we need to do it this way?” “is there someone we can work with who can help us in this situation?”. The evidence is that where leaders have transformed their organisations, their characteristics are the opposite of the ‘heroic” type are typically humble and self effacing and that healthcare outcomes benefit from ‘distributive leadership’ where a range of staff were given decision making responsibilities. (Alimo-Metcalf op cit (2012)

Further evidence for the impact of the target setting and performance management culture presided over by successive Ministers comes from a survey suggesting this has encouraged recruitment and development of a certain type of “leader:
they are “high on over-confidence” and suffer from “an absence of attention to
detail and completion of tasks”….They are “not necessarily understanding their
own limitations” and do not tend to listen to others.


Since job satisfaction, organisational commitment, turnover intentions, and physical and
mental wellbeing of employees are predictors of key organisational outcomes, then the
concept of employee engagement (West M, Dawson J Employee Engagement and NHS
Performance. Kings Fund. 2012) is especially important. West’s previous work
demonstrates that if organisations have good staff engagement, then patient experience
improves, inspection scores are higher and infection and mortality rates are lower whilst
there is also lower absenteeism and lower levels of turnover (Michael West and Jeremy
Dawson. NHS Staff Management and Health Service Quality. Aston Business School,
staff are significantly less likely to make mistakes ( Prins JT, Hockstra-Weebers JE,
Gazendam-Donofrio SM, Dillaingh GS, Bakker AB, Huisman M, Jacobs B, Heijden FM
(2010). Burnout and engagement among resident doctors in the Netherlands: A national
study. Medical Education, vol 44, pp 236–47. 2010) and provide safer patient care
(Laschinger HKS, Leiter MP (2006). The impact of nursing work environments on patient
safety outcomes: The mediating role of burnout/engagement. Journal of Nursing
Administration, vol 5, pp 259–67).

The IHI research on DH culture (IHI op cit) described how “Virtually everyone in the
system is looking up (to satisfy an inspector or manager) rather than looking out (to
satisfy patients and families)” and “managers ’look up, not out.” It added “we were
struck by the virtual absence of mention of patients and families in the overwhelming
majority of our conversations, whether we were discussing aims and ambition for
improvement, ideas for improvement, measurement of progress, or any other topic
relevant to quality.”

The ascendancy of general management since the “Griffiths report” (1983) has led to
concerns that the lack of professional accountability of general managers alongside the
erosion of clinical (especially medical) leadership has assisted the flourishing of an
environment in which clinical challenge to general management is difficult:

My contention is that the imbalance between the power of managers and doctors,
which Griffiths set in train, is harming patients. This imbalance of power plays out
in many ways. Managers, who do not have an ethical or regulatory body
equivalent to the General Medical Council, can report a doctor to the GMC, and
even if the GMC finds no fault with the doctor’s behaviour, the doctor may still find it difficult to get another job in the NHS. There is little or no opportunity for redress in terms of the manager’s behaviour. Doctors, who—after going unsuccessfully through the appropriate internal channels—publicly complain about situations that they consider compromise patient safety, have occasionally been dismissed by their hospital trust. If an employment tribunal finds that a doctor, or other member of staff, was wrongfully dismissed or treated badly by the trust, that doctor may have considerable difficulty obtaining further employment in the NHS.

*Jarman, J BMJ 2012;345:e8239*

One casualty of the imbalance between financial risk and clinical risk is the quality of care and what several reports, the Chief Nursing Officer and Ministers have identified as a “lack of compassion” in some NHS care. Robert Francis described how on some wards in Mid Staffordshire the most basic standards were undermined or ignored. An evidence review of the evidence on the causes of this was commissioned by the NHS NW. It concluded:

1. 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
2. Compassionate care results from the interaction between nurses and the organisational and social contexts of nursing
3. Organisational culture, policy and politics can exert a damaging influence on caring values

Evidence shows that politics, policy and organisational culture can and do exert a damaging influence on professional values, but this is not surprising when the social welfare ideals on which the NHS is built are being systematically dismantled.


Jeremy Hunt, 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". (our emphasis) (Care failings are betrayal of NHS values, says Jeremy Hunt. The Guardian, 6 January 2012)

The Chief Nursing Officer calls for nurses to have the “courage” to speak out when a lack of compassion, poor or unsafe care exists or is likely. (Compassion in practice – nursing, midwifery and care staff – our vision and strategy. NHS England 2012)). We suggest that the evidence is that such courage too often brings unacceptable risks to the treatment, employment, career or health of those who do so, and that a crucial reason why staff do not always show such “courage” is a rational decision that the damage to one’s self and one’s family may outweigh the damage to the risk to patients or the breach of ethical behaviour silence involves. We have to ensure that changes.
4. Why are whistleblowers important?

Robert Francis recommended that “openness, transparency and candour” must be central to preventing any similar scandal to Mid Staffordshire. (Francis (2013) Recommendations 173-179). He recommends “openness” because it will enable “concerns and complaints to be raised freely without fear and questions asked to be answered; “transparency” because it will allow “information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and a statutory “duty of candour” so that any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.” He seeks to prevent “gaming” of performance indicators or the provision of misleading information by recommending the duty of candour become contractual for both staff and non executive directors

Recommendation 179 removes “gagging clauses” on whistleblowers over public interest issues of patient safety and care to signal a change of culture. He says that “whistleblowing is only necessary because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns. If that culture is absent then raising concerns external to the system is bound to be a difficult and challenging matter exposing the whistleblower to pressure from colleagues”.

Patient safety literature suggests there should be little need for “whistleblowers” in an open, transparent, learning culture because all staff are encouraged and expected to raise concerns about patient safety or poor care which should be addressed in a speedy and effective manner. (Reason, J. (1998) Achieving a safe culture: theory and practice Work and Stress,)

When whistleblowers raise concerns their claims are often turned into employment disputes and are either denied or they are accused of acting in “bad faith” (PCAW evidence).

Yet there is plentiful evidence of the positive role they have played or could have done as advocates for patient safety, staff wellbeing and the public interest had they not been victimised:

Notwithstanding repeated assurances that gagging clauses are abolished, a climate of fear continues such that virtually no whistleblower other than Gary Walker has publicly breached their gag. We consider below the other ways in which staff are prevented from
raising concerns or in which public interest concerns are turned into “contractual employment” matters.
5. What happens to NHS whistleblowers?

There have been numerous exhortations from Ministers and NHS Chief Executives stressing the importance of whistleblowing since the Public Interest disclosure Act 1998 (PIDA) became law. Health Service Circular 1999/198 ("The Public Interest Disclosure Act 1998: whistleblowing in the NHS") required every NHS trust and health authority to have in place policies and procedures which comply with PIDA. “Speak up for a healthy NHS” (Speak up for a healthy NHS. DH and NHS Social Partnership Forum. 2010) urged employers to have good policies and practice in place. NHS Employers more recently stressed early intervention when concerns first arise about an individual doctor. The Secretary of State for Health published an updated NHS Constitution in March 2012 stressing the responsibility of staff to report concerns and of employers to act on them. (The NHS Constitution for England DH. March 2012) Guidance for GPs was issued following the Shipman Inquiry report. (Whistle-blowing for a healthy practice Public Concern at Work NHS Employers. 2003). Additional circulars have been issued since the Francis Report was published in February 2013.

Despite this, the research referred to earlier in this Briefing has confirmed very significant shortcomings in the protection and support offered to whistleblowers. There have been shortcomings in:

- How employers and regulators have promoted whistleblowing
- How employers and regulators have responded to whistleblowing
- How employers and regulators have failed to play their part in bringing about an open, transparent and just culture in which whistleblowers are treasured not victimised, and in which everyone eventually becomes a whistleblower.

Much has been made of the likely impact of subsequent circulars and letters to the service, and the abolition of gagging clauses. Almost every single NHS organisation with authority in this field jointly signed the Speaking Up Charter http://www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/RaisingConcerns/SpeakingUpCharter/Pages/SpeakingUpCharter.aspx whilst the NHS chief executive assured the Public Accounts Committee that the ban on gagging clauses was “retrospective” though it remains entirely unclear what this means.

Robert Francis QC, having expressed considerable concern that the culture at mid Staffordshire was not conducive to staff raising concerns about patient safety and poor care (Francis, 2013: 1.111) called for better support for whistleblowers and an end to “gagging clauses”, or compromise agreements which prevent staff raising such issues through a confidentiality clause (Recommendation 179)
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.

The promulgation of documents such as Speaking Up whilst helpful is setting the standard that NHS employers should meet will only be effective if it is part of a concerted effort to change the entire culture of the organisation to one of openness, transparency and candour in which everyone feels able to raise concerns freely so there is no need to “whistleblow”.

It surely says something about the resilience of NHS employers in avoiding their duties under the Public Interest disclosure Act that so many letters, circulars and declarations of intent have been necessary to try to provide the protection that the law provides and which the evidence says is good for patient care.

**The lifecycle of the whistleblower**

Our experience in Patients First, and we believe that of others who advise, support and monitor whistleblowers is that if a member of staff raises serious public concerns which might reasonably be regarded as “protected disclosures” under PIDA which management choose, for whatever reason to ignore, deny or resist then the consequences for staff can be (and often are) very serious indeed.

It is perhaps worth stating that it is almost unheard in our experience for an NHS whistleblower to be promoted. It is equally unusual for a whistleblower, whose concerns are found to be threatening by those to whom they reported them, to not suffer adverse consequences of some kind. It is normal for whistleblowers to be ignored, obstructed or victimised, notwithstanding the plethora of supposed legal protection, the intention of the NHS Constitution, or Ministerial circulars.

That does not mean that all staff who report incidents or raise concerns are victimised in some way. Many staff do manage to report incidents or raise concerns without that happening. Indeed raising concerns should be part of normal everyday business.

We have had to draw the conclusion, based on our own experiences and evidence, that the surveys referred to in Part 2 of this Briefing do accurately portray a very serious and continuing problem in which very significant numbers of those staff who, in good faith and in the public interest, raise concerns within their NHS employer do suffer detriment for doing so, are rarely thanked for doing so and are almost never subsequently
promoted, or even in many cases reinstated into jobs they should never have been dismissed from.

Here we detail the pattern of typical response by too many employers to a member of staff who has raised serious public concerns which might reasonably be regarded as “protected disclosures” under PIDA and which management chose, mainly because one can only assume, the disclosures exposed them for their own inadequacies, resource deficiencies, or for serious avoidable error.

**Stage one**

1. Fail to acknowledge the concern in a timely manner leaving the whistleblower concerned that the matter of concern is being ignored or even continues.
2. Fail to accept that the concern is genuine and/or serious on the grounds such as that “no one else has complained” or “we disagree with your view” in fact staff do not need to be right in raising their concern, they just need to raise it in good faith.
3. Explain that nothing can be done because “there are no additional resources or staff” and appeal to the member of staff to “be patient” because “everyone is doing their best” We know that many of nursing concerns relate to staffing (RCN survey).
4. Explain that the concern has been addressed when it self-evidently hasn’t been. This can be done by use of an “independent investigation”, which is often neither independent nor a proper investigation taking account of all perspectives. The whistleblower is often lucky to be informed of the investigation or given a copy of the full report if one is produced. Eg Sibert report, Phillips report and so forth.
5. Point out that the concern raised can be seen as criticism of colleagues and should it not turn out to be true then this could result in a “difficult situation” or indeed in disciplinary action for a malicious or vexatious complaint.
6. Invite the whistleblower to withdraw their concern, reminding them directly or indirectly that this “doesn’t look good” on any future reference. Even if that isn’t done, the whistleblower will generally have been completely taken by surprise by the management response and may well withdraw the concern, or go off sick, possibly never to return.
7. If that doesn’t work suggest that the whistleblower withdraws the concern and agrees that the manager will look at it “less formally” and then proceed to “encourage” staff to raise incident concerns informally with the manager before submitting them, whether or not this accords with the Trust procedure.
8. As far as possible, ensure that the concern raised doesn’t go anywhere near the trust “risk register”.
9. Continue to give no feedback on whether anything has been done arising from the concern raised so the member of staff has no idea whether it is being ignored.

**Stage two**

10. Marginalise the whistleblower by missing them off the invites to meeting that would normally be attending, or miss then off emails they would normally be included in, or invites to training events/CPD they would normally attend.

11. Undermine or overload the whistleblower by withdrawing essential resources or simply not providing them. These might include administrative support, equipment, failure to provide sick cover for colleagues that might normally be provided, increasing the caseload, changing their shift patterns or their work base or working area. There are many subtle ways that staff can be undermined and treated differentially to their colleagues, which increases the level of stress on individuals and makes many feel like resigning.

12. Excessively scrutinise the whistleblower’s work by calling in records, increasing inspections, more one-to-ones, or bringing forward appraisals.

13. Advise work colleagues that it wouldn’t be a good idea to give support, be a witness or over-fraternise with the whistleblower. Suggest that they are not well, have “problems at home” or imply that the whistleblower has been critical of colleagues even if they haven’t. This can be done more or less subtlety. This is some cases has been done openly. If an employer is trying to drive out a whistleblower then this sort of behaviour might even be encouraged.

14. Find a complaint to use against the whistleblower and if one doesn’t exist, encourage someone to make one. This can be a colleague saying “X is a difficult person to work with”, or “I have some concerns about your work”. Every member of staff makes mistakes. Instead of being learning events these become opportunities for harassment. A fishing trip in anyone’s work is likely to find something wrong, missed or unclear. There are a number of examples where whistleblowers have been referred to the GMC/ NMC and have suffered prolonged investigations before being declared as no case to answer but the damage has been done.

15. Raise concerns about the impact on the health of the whistleblower arising from the act of whistleblowing up to and including “you seem very stressed” “are you sure you should be at work” or even “I think you may be a bit suicidal”. Then suggest or insist on a period of sick leave.

16. Suspend the whistleblower on the grounds that there needs to be an investigation into their work, or behaviour. If the whistleblower wasn’t stressed before, they
certainly will be now. Ignore Tribunal decisions suggesting suspension may often not be appropriate (UKEAT/0338/10/DA Crawford and Another v Suffolk Mental Health Partnership NHS Trust. At Para 79).

17. Emphasise to the whistleblower that the suspension is a neutral act but also that they must not contact any work colleagues or discuss what has happened – even if their best friends are workmates. This is an aggressive act.

18. Take plenty of time to conduct the investigation, the longer the better. Many staff off work more than six weeks never return to work. (Carol Black. Working for a healthier tomorrow – a comprehensive review of work and health. (2008)) Being suspended is a lonely, demoralising existence.

19. Consider a restructure of the team, department or the work itself after which the whistleblower may be redundant, demoted, transferred to a different team or department. We have evidence of staff being got rid of as redundancy when in fact it was unfair dismissal.

20. Spread the word round the department or team that the whistleblower is unlikely to come back, including moving their desk or changing their rol, even clearing their desk.

21. If at all possible make sure an investigator is appointed who understands that a decision that there is “a case to answer” on all or some of the allegations should be found. If NCAS are involved make sure a convincing set of management witnesses are lined up

Stage three

22. Meet the whistleblower and outline the steps underway to either make them redundant or restructure them. At this meeting suggest that there might be an alternative way forward which, in the light of “differences with colleagues” or “what is best for their career” or their “health” might involve

- retirement on favourable terms due to ill health or restructure
- redundancy on favourable terms (which might not otherwise be available)
- leaving with a good reference before any disciplinary process gets underway (or even during it)

23. If the whistleblower is on sick leave remind them that payment will not be for an unlimited period. Keep chasing them.

24. Refer the whistleblower to the professional regulator (e.g. NMC, GMC, HCPC) or warn them that this is under consideration
What won’t happen once matters have reached this stage?

25. Extremely unlikely that anyone will say “sorry we made a mistake”.
26. Extremely unlikely that anyone will say “thank you for highlighting this problem, we’re going to deal with it”
27. Extremely unlikely that if a disciplinary hearing is held that the outcome will be to clear the whistleblower of all charges
28. Extremely unlikely that any counter allegation of bullying, abuse of process, or breach of duty of care by the employer will be upheld or even properly investigated. Discourage witnesses.

How will it end?

29. The whistleblower will start to realise that whatever now happens their career in this particular employer has a serious cloud over it and they may better off leaving
30. The pressures from family and friends may convince them to find a “way out”
31. The worry of being dismissed or being unemployable will become more important
32. Their lawyer or trade union official (or both) may suggest that some sort of “compromise agreement” might be the way out of this situation, partly for their health and partly because either the “legal advice” is they their chances of winning in court are not good, or because what the Trust are offering is as much as they would win in court without the upset and stress – and they will get a reasonable reference without which a future career is impossible.
33. Most whistleblowers find it impossible to keep going and are eventually relieved if still angry that they have left the employer, even if their career may be in ruins.

Patients First’s files continue many variations on these themes. Many NHS employers have been adept at turning public interest concerns into employment disputes. Similar variants on these themes are well known (Hammond, P, Bousfield, A. 21 Ways To Skin An NHS Whistleblower (2011)). The impact was well summarised in Fig 1.

Implications

This “lifecycle” is essential to understanding why the existence of whistleblowing policies and the abolition of “gagging clauses” hardly scratch the surface of the problem. By the time the whistleblower leaves, their primary concern is their health, their family, their future job, some financial cushion, and to see the back of their employer. For many, the original whistleblowing concerns pale into insignificance, especially as they will be told they can still raise them but in practice most will not because the price will be that they will struggle to work again in their profession. As research a decade ago put it:
The greatest fear is that of reprisals from the employer, associates of the bully, and powerful professionals, who may close ranks and compromise the career of the whistle blower

Field T, Becker K, Mackenzie GM, and Crossan L. Bullying in medicine. BMJ. 2002; 324: 786.

Fig 1. The effects of going through a dismissal process on various domains of well-being, depending on the severity of the impact

<table>
<thead>
<tr>
<th></th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
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<tbody>
<tr>
<td>PROFESSIONAL</td>
<td>Insecure</td>
<td>Deskillled, Difficult to Get Work</td>
<td>Unemployable</td>
</tr>
<tr>
<td>REPUTATIONAL</td>
<td>Stigma</td>
<td>Spurned by Others</td>
<td>Reputation Destroyed</td>
</tr>
<tr>
<td>FINANCIAL</td>
<td>Strain</td>
<td>Use Most of Savings</td>
<td>Have to Sell Home</td>
</tr>
<tr>
<td>HEALTH</td>
<td>Minor Complaints</td>
<td>Major Illness</td>
<td>Death</td>
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<tr>
<td>EMOTIONAL</td>
<td>Anxious</td>
<td>Depressed</td>
<td>Suicidal</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>Isolated</td>
<td>Marginalised</td>
<td>Ostracised</td>
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<tr>
<td>FAMILY LIFE</td>
<td>Disrupted</td>
<td>Major Strains</td>
<td>Divorce, No Contact with Children</td>
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Independent whistleblowing charity Public Concern at Work concluded, after commissioning a review of one thousand whistleblowing inquiries that:

“Public inquiries and scandals across many sectors have highlighted the vital role that whistleblowing can play in the early detection and prevention of harm. But too often questions are asked after the damage is done. From the LIBOR banking scandal, the Mid-Staffordshire hospital inquiry and the Leveson inquiry into phone hacking, it is clear that staff did express concern that wrongdoing or malpractice was taking place. The worrying truth is that they are often ignored or worse, discouraged, ostracised or victimised.”

“Media attention on whistleblowing makes for contradictory reading: ministers and employers say whistleblowing is vital for an open and transparent workplace culture, but ask the whistleblowers and the story is starkly different: they are gagged in the NHS, arrested in our police forces and blacklisted in many industries. “

“The combination of the findings in our report demonstrate why speaking up in the workplace may seem futile or dangerous to many individuals. While organisations may be getting better at addressing wrongdoing, they are still shooting the messenger and overlooking crucial opportunities to address concerns quickly and effectively. “

“Too many workers still suffer reprisal which will not only impact negatively on the whistleblower, but will deter others from speaking up and allow a culture of silence to pervade. We must learn from past mistakes and make sure that whistleblowing protects individuals, organisations and society as a whole.”

An academic analysis of the ten years of the Public Interest Disclosure Act 1998 concluded that

"PIDA 1998 has not adequately protected whistleblowers and makes 12 recommendations for change. Despite the European Commission's acknowledgement that whistleblowers can play a part in the fight against corruption, the author notes that the common standards for their protection is a long way off". (Lewis, D. Ten Years of Public Interest Disclosure Legislation in the

The Public Interest Disclosure Act 1998 and employers’ own procedures strongly encourage staff with concerns to raise them internally prior to considering whether to raise them externally with a statutory regulator such as the Care Quality Commission or the media. In practice many concerns are raised internally using systems such as “incident alerts” which should both address specific concerns and enable patterns of concerns to be identified. However we believe that the stream of initiatives to “protect” NHS whistleblowers suggest a recognition that for a significant number of staff who do raise concerns, it can still be dangerous or even career ending. (Holt, K and Kline, R “Whistle while you work - if you dare” Health Service Journal 25 October 2012)

Patients First is aware of a large number of high profile whistleblowers whose careers have suffered or been ended as a result of raising public interest issues of precisely the type that their professional codes require them to. There has been extended media reporting of some high profile cases (Lakhani N Hung out to dry: scandal of the abandoned NHS whistleblowers. The Independent, 4 July 2011; Bousfield, A and Hammond, P. Shoot the messenger. Private Eye November 2011. http://drphilhammond.com/blog/wp-content/uploads/2011/11/Shoot_the_Mesenger_FINAL.pdf)

**Ten cases illustrating what happens to many whistleblowers**

**Dr Steve Boslin**

Dr Steve Boslin, the anaesthetist who finally exposed paediatric heart surgeons in the Bristol babies scandal in 1995, moved to Australia after being ostracised by the NHS. Despite initially being post only two months Bolsin raised his concerns repeatedly with senior consultants and the trust chief executive, and alerting the Department of Health when his evidence failed to stop unsafe working practice. 19 years after Steve Bolsin’s first concerns a public inquiry concluded that a third of the children undergoing surgery prior to 1995 had received “less than adequate care” and that between 30 and 35 had died, and many others were harmed, unnecessarily. The Bristol tragedy was avoidable. Had those in authority acted promptly on Bolsin’s concerns, the scandal would never have happened. Many more babies’

Bolsin, now a leading thinker in patient safety, was described as “the most hated anaesthetist in Europe” at a European cardiac surgeons meeting, and found himself unemployable in the NHS.
(Source Private Eye)

**Sharmila Chowdhury**

Sharmila Chowdhury, a radiographer with an unblemished 27-year NHS career, was marched off the premises following an unfounded counter-allegation of fraud made against her by a junior whom she had reported for breaching patient-safety procedures. Ms Chowdhury's employer, Ealing Hospital NHS Trust, has spent hundreds of thousands of pounds getting rid of her, leaving her depressed, unemployed and broke. After an employment tribunal judge found in her favour, the Trust decided to make her redundant. Eventually she did lose her job after the Trust spent large amounts of NHS funding on legal costs and a severance payment which was the only way she could prevent her home being seized. Radiology service manager Sharmila Chowdhury revealed allegations that doctors were being paid to see NHS patients while they were actually moonlighting with their own private patients. Ealing Hospital NHS Trust sacked Ms Chowdhury but a Watford employment tribunal judge ordered that she be reinstated. She has subsequently been victimised and made redundant – after facing legal fees of more than £100,000 to defend herself.

Sharmila is an active member of Patient First

**Dr David Drew**

David Drew was clinical director the paediatric department in Walsall, and raised concerns about a colleague who had sent a child home against policy. This child was then killed by his carers. Dr Drew was eventually dismissed after having raised concerns a number of times with the medical director and his Chief Executive and Chair.

He has suffered severe coronary artery problems and currently is recovering from this but his story has been fully investigated and will be in the public domain. He would of course be willing to submit any documents that are needed by the commission to fully understand his case.

The BMA represented him initially but then wished for him to settle and once he refused to sign a gagging clause they withdrew heir support for him. He was then left to fund his own legal case.

David Drew is an active member of Patients First

**Jennie Fecitt**
Jennie Fecitt was one of three nurses who raised concerns about a colleague who had exaggerated his qualifications in discussions with staff at the NHS Manchester walk-in centre where they worked.

It sparked a four year dispute with their employer that ended in the three nurses being forced to pay £21,000 of NHS Manchester’s legal costs, despite writing to then health secretary Andrew Lansley asking him to intervene.

Ms Fecitt and her colleagues Annie Woodcock and Felicity Hughes faced daily personal insults and threats from colleagues after raising concerns in 2008. Hours dried up completely for regular bank nurse. Ms Hughes, while the other two were transferred to different roles within NHS Manchester.

They took the primary care trust to an employment tribunal claiming they had suffered unlawful detriment in being moved from the centre, while the colleagues who had victimised them remained in post. However, the judge ruled NHS Manchester could not be held responsible for the actions of its employees under the Public Interest disclosure Act.

They were successful in their appeal. But NHS Manchester refused to accept the decision and took the case to the Court of Appeal, which upheld the original decision and ordered that they pay some of the PCT’s legal fees.

The three nurses were offered a compromise agreement worth £160,000 between them to settle out of court. However, this would have involved them signing a so-called “gagging clause” and they chose to fight on to prove the principle that employers had a duty to protect whistleblowers from discrimination as a result of their actions.

Jennie Fecitt is a member and lead nurse of Patients First

**Margaret Haywood**

Margaret Haywood was struck off the nursing register after she went undercover for a BBC documentary, exposing poor standards of care for elderly patients at a Sussex hospital. Five years later she was reinstated by the Court of Appeal.

A decade later the Nursing and Midwifery Council’s decision to discipline nurse Margaret Haywood for breaching confidentiality when she raised concerns over poor patient care illustrated the personal cost whistleblowers still paid and the slow progress professional regulators had made in recognising the need to protect whistleblowers.
Dr Kim Holt

There is extensive documentation that supports this case as an example of the many strategies used against whistleblowers but also of an individual who went to every possible place for support and received none.

She was best supported by her colleagues, her husband, her MP and the media.

She made disclosures to the MP, CQC on two occasions, the GMC and also the SHA NHS London.

Key documents are;

The protected disclosure letter written by four paediatricians in 2006

Sibert report, an independent investigation into the practice of Dr Al Zayyat by Professor Jo Sibsert and Dr Deborah Hodes, April 2008 released on FOI in 2011.

Witness statement by Dr Hilary Cass chair of the grievance panel against Jane Elias AD of Haringey in 2007. Dr Cass testifies to significant amendments to the outcome of the hearing and that she regretted her actions.

CQC report into the health failings of the organisations involved in baby P.

NHS London report December 2009 online.

Feedback to the NHS London report by Dr Kim Holt dated September 2009, available on request.

Note written by the BMA at the start of mediation in 2010.

Mediation report from December 2010

Letter before action written by BMA lawyers to Great Ormond Street Hospital, in 2011 on two occasions. Available on request.


Apology to Dr Holt in June 2011

Settlement agreement on settlement of a personal injury claim with Dr Holt in June 2011.

Kim Holt is an active member and Chair of Patients First
Dr Ed Jesudason

Dr Ed Jesudason is an award-winning surgeon who has never received a patient complaint or malpractice suit. In 2009 he protested when Ahmed was suspended by UHNS after AHCH colleagues made the unsubstantiated claim that he was suicidal. The Eye has seen a 5.9.10 letter from surgeon Colin Baillie to AHCH which reads: “Shiban mentioned he had considered suicide. I have no doubt this was what was said because I asked him to repeat himself. I shared this with the clinical director Matthew Jones.” Ahmed knew nothing of this. He was suspended for 14 months pending an investigation which cleared him of being any risk to himself or his patients. He is still not back at work a Royal College of Surgeons (RCS) report found that “many members of the departments spontaneously described Jesudason and Ahmed as exceptionally skilled and talented surgeons”.

Jesudason led the petition to reinstate Ahmed and in 2009 made a confidential protected disclosure to AHCH which was circulated to his consultant colleagues, some of whom now refuse to work with him.

“The public interest disclosure act offers no real protection to whistleblowers against trusts with vast legal resources, and the CQC has shown no interest in policing trusts that break their own whistleblowing codes with impunity.” The trust now belatedly accepts Ed Jesudason is a whistleblower, but argues that concerns regarding his working relationships with other surgeons have nothing to do with his protected disclosure in 2009, but ‘date back to 2004’, despite the fact that his colleagues now seeking his removal interviewed and appointed him to a consultant post in 2006.

Ed Jesudason, a brilliant paediatric surgeon and researcher who has never had a patient complaint against him, blew the whistle on his colleagues at Alder Hey refused to take a gag and has now resigned with his NHS career in tatters.

Jesudason raised concerns about many issues. Fellow surgeons were doing procedures on vulnerable children that were unnecessary and experimental, without any research approval or informed consent. Senior surgeons were complaining of severe stress and burnout due to workload and this was accompanied by eyesight and other health concerns. Children were at risk because major errors went unreported and even those that were discussed went uncirculated as minutes. The senior surgeons and Clinical Director showed no urgency to have better scrutiny so errors repeated themselves. There was a culture of widespread and severe bullying by stressed senior surgeons. And then two colleagues fabricated a suicide claim against a whistleblowing colleague, leading to his suspension. As Jesudason puts it: ‘This was a point where it was clear we were dealing not with misfeasance but clear malfeasance.’
He lost his case in the High Court because he refused to take a gag and admitting passing information to Private Eye. The Public Interest Disclosure Act is supposed to protect whistleblowers who share serious concerns with the media in good faith but the judge ruled that some of the material appearing before the trial would prejudice him. Jesudason resigned, with costs against him that have forced him to sell his house. His marriage has ended and he is struggling to find work as a surgeon.

When Private Eye contacted Alder Hey Childrens Hospital to ask about gagging orders, the answer was very firm: “Alder Hey has never placed gagging orders on any member of staff.” But the Eye already had in its possession the compromise agreement relating to a senior child heart surgeon, Mr Marco Pozzi, and the amount he was paid, namely £156,000.

(Source Private Eye)

**Professor Narinder Kapur**

Professor Narinder Kapur was dismissed as a consultant neuropsychologist and head of neuropsychology at Addenbrooke's hospital in Cambridge after voicing his concerns about staff shortages and the impact on patient care several times. A tribunal ruled that he had been unfairly dismissed, yet he was never reinstated. He said

“I had a duty to do so on behalf of my patients, but I was repeatedly ignored by the hospital senior management.

“They refused to pay any attention to me. If that can happen to a professor like myself, with a worldwide reputation in his field, imagine what happens when more junior members of staff try to raise the alarm.”

Cambridge University Hospitals NHS trust (CUH) dismissed Prof Kapur in 2010, claiming there had been a breakdown in their relationship because of his management style and working methods. It also suggested he had been involved in fraud involving hospital funds.

But last July an employment tribunal ruled that he had been unfairly dismissed. The tribunal found the trust “did not conduct itself as a reasonable employer in this regard” and it condemned its attempt to accuse Prof Kapur of fraud. In its judgment, the panel stated: “There is no question whatsoever of Dr Kapur doing anything other than manipulating a financial system in order to ensure that his patients’ best interests were fulfilled in circumstances where he was dissatisfied with the resources at his disposal.”
It added: “The tribunal condemns unreservedly the way in which the NHS has conducted itself in respect of this allegation. It proved unwilling to accept without some probing by the tribunal that the position was now closed and Dr Kapur was not found to be involved in activity that could be categorised as fraudulent.”

However, the tribunal found that Prof Kapur had not been sacked because of his whistle-blowing, but because there had been “an irredeemable breakdown in trust, confidence

Prof Kapur said: “Many whistle-blowers are forced to give up because it becomes so hard to continue. Some have nervous breakdowns or they can’t afford financially to carry on.

Some even kill themselves — and I’ve come close to that at times — because they appear to have no support against an aggressive employer.

“But I’m fortunate. I have the determination, the knowledge and the resources to be able to carry on. What’s more, I’ve got a moral imperative to stand up on behalf of other whistleblowers.”

Faced with raising £300,000 of tribunal costs, Prof Kapur had to sell his family’s home in Southampton. He has also had to cash in his pension.

Protect NHS whistleblowers urges consultant who lost job and home after raising concerns Patrick Sawer, and Laura Donnelly 26 May 2013

Dr Ramon Niekrash

Dr Ramon Niekrash was a 50 year-old consultant urologist who found himself suspended after speaking out against cost-cutting at Queen Elizabeth Hospital in Woolwich, South London, a place where he had worked for around ten years. A tribunal ruled that he had been unfairly treated and was entitled to damages because he had been acting as a whistleblower in the public interest. It is reported that at one point during his dispute at work, a senior doctor at the hospital allegedly stated that she wished that Mr Niekrash, who had trained in Australia, was ‘in chains on a plane in Heathrow back to Australia’. The employment tribunal judge is reported as noting, “We have no doubt that the exclusion of a consultant, being a rare occurrence, must have an adverse impact on the claimant’s reputation”.

Dr Niekrash warned that health professionals need think ‘very hard’ before raising concerns about poor patient care, because it is ‘potential professional suicide’. ‘Your employer won’t thank you; the law won’t protect you. You’re on your own’. He was suspended from work by the medical director and head of human resources. He was
apparently only reinstated after senior doctors threatened a vote of no confidence in the Trust.

The tribunal found in his favour but left him with £160,000 legal bills. The trust used taxpayers’ money to pursue its vendetta. All the managers involved are still employed by the NHS and some have been promoted.

*April 2010 article in The Independent newspaper*

**Kay Sheldon**

Kay Sheldon was a Board member of the Care Quality Commission. She contacted the Mid Staffordshire Public and told the Inquiry that her main concern was that the organisation (CQC) was badly led with no clear strategy. The chair and the chief executive do not have the leadership or strategic capabilities required. She was also concerned that the CQC kept repeating the same mistakes, and did not consider whether it had sufficient capacity to do annual inspections. She described the strategy as “reactive” and driven by “reputation management and personal survival”. CQC chair Dame Jo Williams asking for Sheldon to be sacked, having first tried to push her out on ground of her “mental health”. Subsequently Sheldon’s claims proved to be right and both Cynthia Bower and Jo Williams resigned. Has she been listened to, the CQC might have acted much sooner in, for example, Mid Staffordshire.

**Gary Walker**

The demand for emergency hospital beds in 2008 and 2009 became so acute that it was felt by Gary Walker and the board of United Lincolnshire Hospitals Trust (ULHT) they felt they had no other choice than to abandon the 18-week Whitehall target for non-emergency cases. Mr Walker warned senior civil servants that he faced the same dilemma that led to disaster in Mid Staffs. In 2010, he was sacked as chief executive of the United Lincolnshire Hospitals Trust (ULHT) on grounds of "gross professional misconduct" for allegedly swearing in a meeting. He and former trust board members have repeatedly stated that the real reason lay in his refusal to hit Whitehall targets for non-emergency patients. Three years later, ULHT is one of 14 hospitals in England currently being investigated for high deaths rates, in the wake of the Stafford hospital scandal, where hundreds are believed to have died after receiving poor care. Gary Walker said he had no choice but to sign an agreement linked to a confidentiality clause in April 2011. He said it was a case of either signing the so-called "super gag" agreement or losing his house. He said: "I was in danger of losing my house - I have children to
support. And one thing you must remember that if you’re attacking the very top of the NHS the sanctions are pretty dramatic. "So I spent 20 years in the health service and I’m blacklisted from it. I can't work in the health service again."

John Watkinson

John Watkinson was sacked as chief executive of the Royal Cornwall Hospital NHS Trust in 2007 after he refused to remove cancer services without first consulting local people. An employment tribunal awarded him nearly £900,000 in compensation; he has been unable to find another job. ONE of John Watkinson’s first actions as CEO of Royal Cornwall Hospitals NHS Trust (RCHT) in January 2007 was to bring back to work two employees who had blown the whistle on the trust for making false declarations. Eighteen months later, Watkinson was suspended and subsequently dismissed for whistleblowing plans to move cancer services without the legally-required public consultation.

RCHT was the worst performing trust in England, with a £35m debt and staff utterly demoralised. Within a year, Watkinson delivered a £1.2m surplus and RCHT was in the top four A&E performers in the country. Then NHS South West, the SHA, decided to concentrate upper gastro-intestinal services in Plymouth, with Cornwall and Exeter forming a centre of excellence. Two statutes say that such major service changes require formal public but neither the SHA nor the PCT wanted delay. Watkinson’s chairman, Peter Davies, resigned over the issue and when Watkinson sought legal advice confirming the obligation to consult publicly, his days were numbered. He was sacked six months later. An employment tribunal found Watkinson had been “got rid of” because of his support for doing what the law requires. The findings were damning of RCHT and the SHA and it awarded him £1.2m compensation, now reduced to £900,000. Private Eye revealed that RCHT has already spent £400,000 on legal costs. Watkinson has spent a similar, non-recoverable, amount of his own. Watkinson lost a 35-year career, any prospect of employment and a £150,000 a year salary. Suspension required him not to talk with former colleagues, while not a single NHS chief executive – of whom he knows dozens – has been in contact since his case began.
6. Government, the law and employer policies

'If the culture is unethical, acts of heroic staff may be futile'


The NHS Constitution identifies three key expectations relating to whistle blowing:

- An expectation that staff should raise concerns at the earliest opportunity

- A pledge that NHS organisations should support staff by ensuring their concerns are fully investigated and that there is someone independent, outside of their team, to speak to

- Clarity around the existing legal right for staff to raise concerns about safety, malpractice or other wrong doing without suffering any detriment.

The General Medical Council in Good Medical Practice: Raising concerns about patient safety requires of doctors:

1. **6. If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.**

It goes on to caution that

"You may be reluctant to report concerns for a variety of reasons including, for example, because you fear that this may cause problems for colleagues, adversely affect working relationships, have a negative impact on your career or result in a complaint about you."
The RCGP (Position Statement: NHS Whistle Blowing January 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."

The NMC Guidance similarly requires registrants:

1 As a nurse or midwife, you have a professional duty to report any concerns from your workplace which put the safety of the people in your care or the public at risk.
2 The code stipulates:
   2.1 you must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk
   2.2 you must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards
   2.3 you must report your concerns in writing if problems in the environment of care are putting people at risk
   2.4 as a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.

Raising and escalating concerns Guidance for nurses and midwives. NMC 2010.

NMC research conducted whilst developing its guidance in 2010 found the fear of being victimised after blowing the whistle is a major barrier to nurses and midwives reporting problems. The NMC surveyed 56 organisations and 395 nurses. Many expressed fears about the implications for individuals of raising concerns, particularly the risk of victimisation, being stigmatised as a “troublemaker”, bullying or intimidation. The research was commissioned as part of a consultation on draft guidance for raising and escalating concerns. Roughly two thirds thought someone following the draft guidance would still face barriers (Ben Clover. Fear of victimisation stops nurses whistleblowing, says NMC research Nursing Times. 10 August 2010)

A Speaking Up Charter has been endorsed by all significant organisations in the NHS and states:
Safety should be at the heart of all care, and must be underpinned by a just culture which is open and transparent. This leads to increased reporting, learning and sharing of incidents, and best practice.

Individuals providing care services should always feel free to raise concerns through local processes and be supported to do so ………Whilst the existence of compromise agreements between employer and employees generally should not be a cause for concern, compromise agreements containing clauses seeking to prevent disclosures protected under the PIDA 1998 are not acceptable. Policies should be developed and continuously promoted to encourage and enable individuals to report and discuss concerns early on before a serious incident occurs.

Patients First endorses all these principles but we have continuing evidence that despite them, a substantial number of staff who raise public interest concerns suffer denial, detriment or discouragement if their local management does not wish to act on them.

We are in discussion with some regulators, NHS Employers, trade unions and others because it is our continuing experience that notwithstanding the repeated insistence by the Department of Health, NHS England and the Secretary of State, it remains dangerous for staff who raise concerns where their local management disagree, feel threatened, or are in denial about the concerns raised. We believe it is essential that the health Saelect Committee again consider this issue.


They wrote

We speak to professionals in and outside of the NHS on a daily basis. These individuals are keenly aware of their professional duties. Yet they may be working in an environment where they have seen individuals raising concerns, only to be damaged or ignored. Recent media coverage of the issue suggests that any doctor who speaks up will be ignored, suspended or dismissed. This does not wholly correspond with the experience of every professional who calls us, but it is a sadly familiar story. Raising concerns will never be risk - free but it needs to be made safer. Pertinent surveys frequently reveal the reason that most prevents
workers from speaking up is the perception that nothing will be done. As such we consider the following points have precedence over the need to identify and investigate individual professionals who may or ought to have known and did not report:

i. It is a more serious issue for a senior doctor or manager to fail to address a concern or fail to escalate it appropriately.

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.

iii. Establishing a safe environment in which to raise a concern should be a clear responsibility of any NHS trust and the professionals working there. There is a substantial amount of guidance on what constitutes best practice in whistleblowing arrangements, which we have summarised in Annex A. Whether or not this is translated into good practice on the ground is a moot question.

Public Concern at Work went on to make a number of proposals, some of which have now been reluctantly agreed by the Government to:

- Ensure that all GPs have the protection of PIDA

- Ensure all student health professionals have the protection of PIDA to avoid situations where “the education establishment has removed a student nurse from a course after they raised concerns on a ward and neither the hospital nor the university would accept responsibility. As such she was unable to qualify as a nurse and was effectively deprived of her career choice.

Public Concern at Work also report that

“we have noticed a trend in recent times that trusts engage expensive lawyers and top QCs to put forward arguments that attempt to undermine PIDA. Firstly this means large sums of public money are potentially being used to fight those who have spoken up and in some cases even limit the rights of whistleblowers. We refer to the case of Fecitt (and others) v NHS Manchester.....The use of
expensive lawyers is an extremely troubling trend. To reach an even playing field claimants are forced to spend vast amounts of money to bring their claim

An academic authority on whistleblowing confirms that

“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..

(David Lewis Resolving whistleblowing disputes in the public interest: Is tribunal adjudication the best that can be offered? Industrial Law Journal March 2013 Vol 42. No.1)

Lewis points out that if the 8461 whistleblowing cases lodged with a tribunal 44% were settled via ACAS, 31% were withdraw or settled privately, 6% were successful in court and 12% were not. It is unclear how many of these cases were in health and equally unclear how many of the concerns originally raised were openly addressed. A significant minority of those who settled privately or through ACAS, or withdrew, reported they did so for financial reasons linked to the cost of legal fees. Moreover re-employment is almost never awarded by Tribunals. (Ministry of Justice ET and EAT statistics Table 3 April 2011 to March 2012 (2012))

Moving forward: does the abolition of gagging clauses mean whistleblowing is now safe?

The Department of Health has emphasised that in accordance with the Francis report Recommendation 179 “gagging clauses” have been abolished. Alongside the revised guidance from NHS Employers on Compromise Agreements and on Severance Payments (References) it is being claimed that a tipping point has been reached in the protection of whistleblowers. We believe this is one step in the right direction, but does not mean whistleblowers will no longer be obstructed and victimised, or that the NHS is decisively moving away from the culture of bullying and denial.

1. The Public Interest Disclosure Act remains, at least in the NHS, a source of remedy for, not protection against, victimisation for whistleblowing. It has not deterred NHS employers in the past from obstructing and victimising those raising concerns, and there is no reason to think it will for the immediate future not least because there is no bar on, or monitoring of, the expenditure by NHS employers on expensive solicitors and barristers who role has been to deter ET claims and further restrict the law. Those who have in the past commissioned such advice
and representation, and approved such expenditure, have made no statement accepting this was wrong and a number of high profile culprits have been subsequently promoted (as in the case of Gary Walker and Jennie Fecitt, for example).

2. Only a minority of NHS employers have so far sought to make the sea change in culture towards an open, transparent and just culture that Speaking Up refers to and which Patients First is working towards. Until there is a culture where all staff are encouraged to raise concerns, which are then taken seriously even if misplaced, and where mistakes and incidents are largely treated as learning opportunities, not opportunities to blame staff, whistleblowers will understandably remain concerned that as in the past, statements of principle may not translate into real changes of culture on the ground.

3. NHS Employers by sponsoring the Speaking Up Charter and its guidance on The use of compromise agreements and confidentiality clauses (NHS Employers 2013) has demonstrated support for the principles we espouse. However, we do not believe this guidance either adequately addresses the issue of confidentiality since it does not advocate annual publication of the anonymised details by employer of the amount of settlement and the legal fees involved. Nor is it the case that banning gagging clauses containing public interest issues will adequately address the obstruction and victimisation of whistleblowers by other means which we summarised in Chapter 5 above.

4. The CQC, NMC and GMC were all criticised heavily by the Francis Report. They have yet to demonstrate that they are putting in place the proactive protection of whistleblowers that is required. We make some specific proposals in Chapter 7 to remedy this.

5. Trade unions were criticised by the Francis report for insufficient attention to concerns over the implications for patients of employment changes. Trade unions have a decidedly mixed reputation amongst whistleblowers since whistleblowing cases are often complex, time consuming, costly and there may be a conflict between what is deemed to be in the best interest of the whistleblower’s career or health, and the proper investigation of the public interest issue that sparked the original concern. Trade unions need to carefully reflect on how they better support whistleblowers and integrate such work into wider involvement in challenging unsafe service changes.

6. It remains unclear to what extent, if any, the ban on gagging clauses is retrospective. Sir David Nicholson appeared to tell the Public Accounts Committee (18th March 2013) that the ban was retrospective but it is entirely unclear whether this is the case, and if it is, what that means. As a result most gagging clauses have not been breached for fear of the potential consequences.
7. There are no new measures to prevent employers victimising those who raise concerns by turning a public interest issue into an employment issue, thus enabling the employer to cause the whistleblower detriment in the name of enforcing contractual duties.

8. There are no measures to make the bullying of whistleblowers a matter that should lead to disciplinary action against a bullying manager who seeks to obstruct or victimise a whistleblower. Nor are there any proposals to monitor bullying complaints.

9. It may be that the new duty of candour can be drafted in such a way as to ensure that where an NHS employer can be demonstrated to have obstructed or victimised a whistleblower then not only should the chief executive risk criminal charges but he or she should be regarded as no longer fit to be a board director in any NHS organisation.

10. It is unclear how, assuming they apply to them, the compliance of private contractors providing NHS services with the Speaking Up Charter, the ban on gagging clauses and other measures around the duty of candour will be monitored and enforced.

11. Above all, it is still entirely feasible for employers to turn a public interest issue into an employment issue in which the conduct or competence of the whistleblowers becomes the issue not the public interest concern which sparked the employer’s response. 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
   • 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

We are aware that such steps continue to be taken.
7. What should be done?

The “Speaking Up” Charter calls 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._

We work towards a culture which seeks to hold staff accountable where appropriate, but which avoids the “blame culture” which prevents disclosure of errors and mistakes and obstructs learning.

The cost of the NHS blame and bullying culture is not just the quantifiable cost in staff sickness and absenteeism but the impact of not learning from errors and mistakes to prevent them in future. Robert Wachter, a key figure in world patient safety research emphasises:

> When patient safety breaks down it is usually caused by clinical systems and processes rather than individuals.....the leader’s job is (to help) create an environment in which people are given the right tools for doing their jobs and are so comfortable with their role in the organisation that they hold themselves accountable.” (Robert Wachter. Op cit).

Health service leaders could useful learn from the following:

> People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman Author, the Design of Everyday Things

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.
The evidence makes clear that too many staff fear the consequences of not raising concerns, and that those fears are justified in too many (not all) organisations.

Alongside the implementation of Robert Francis’ recommendations must come a coherent and prioritised strategy to implement three key approaches which have been evidenced as central to improved health care:

- A move away from a top down leadership model led by “heroic” (or macho) managers in which there is a sharp authority gradient towards a much more distributed leadership model. The work of Beverly Alimo-Metcalfe (Alimo-Metcalfe B, Alban-Metcalfe J. Engaging leadership. Creating organisations that maximise the potential of their people (2008)) and the work on leadership from the Kings Fund (Leadership and engagement for improvement in the NHS Together we can. Kings Fund (2012)) for example collates some of the evidence and appears to have become the prevailing at NHS Employers.
- An acceptance that staff engagement (not always well defined) make a very significant difference to safety and health outcomes (Michael A West, Jeremy F Dawson Employee engagement and NHS performance. Kings Fund (2012))
- Agreement that without openness and transparency and moving towards a “just culture” it will be impossible to learn from mistakes and errors

We have some way to go. The independent Kings Fund surveyed more than 900 healthcare professionals in early 2013, before Sir David Nicholson announced plans to retire, and found little confidence among frontline staff and managers about those in charge of the service.

- Just one per cent of those polled thought the leadership of the NHS was very good, with 13 per cent rating it as good - compared with 40 per cent who said it was poor or very poor.
- The report found that 73 per cent of those surveyed said quality of care is not given enough priority in the NHS, and warns that those in charge of the health service need to ensure patients are put first.

It says: “In future those leading the NHS at the national level must demonstrate that caring and compassion are core values within the service. This means setting clear national goals for improving quality and safety, and supporting staff to deliver them ... The actions and behaviours of NHS leaders must be consistent with these values and goals.” (Kings Fund. Patient-centred leadership. Rediscovering our purpose. (2013))
At the heart of the challenge we face is openness, transparency and candour with the ability of staff to raise concerns without fear of detriment and have them addressed in a timely way at the heart of those principles.

Robert Francis defined three key principles as follows: ‘recommendations’

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In recommendations 173 – 183 he set out what he believed the practical implications of those principles were. We await the Government response on whether they will all be accepted and if so in what way.

Recommendation 179 on “restrictive contractual clauses” states

“Gagging clauses” or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

Patients First welcomes the Secretary of State’s immediate endorsement of this step.

**Our recommendations**

However important the ban on gagging clauses is, further steps are needed if this is to be part of decisively creating an open, transparent and just culture. However we believe the following further steps are necessary:

**Our recommendations**

However important the ban on gagging clauses is, further steps are needed if this is to be part of decisively creating an open, transparent and just culture in the health service.
However we believe the following further steps would help in shifting the culture, and whilst they may not be all that is needed they would be a significant start in changing attitudes and behaviours in our view,

**Secretary of State**

1. The ban on gagging clauses over public interest issues must be retrospective and a clear statement from the Secretary of State to that effect is needed so that those who have previously been gagged can speak openly in the public interest.
2. Anonymised disclosure to be made to the CQC by employers of all gagging clauses by amount and legal fees incurred within last ten years and to then be published in a “truth and reconciliation exercise”.
3. National NHS awards to be commenced for (a) organisations that best demonstrate they have a “just” culture and (b) individuals who demonstrate courage in raising concerns.
4. Secretary of State to make clear to NHS employers that no future challenges to PIDA ET claims (such as Manchester NHS vs. Fecitt) will be permitted that might reasonably be regarded as undermining the principles of openness, transparency and candour or which in any way might.
5. A national hotline to the Department of Health to be established DH to log all whistleblowing concerns raised locally. This data to be held separately from that held by any other agency as a record that concerns were raised.
6. Boards where gagging has been discovered by the Secretary of State to be held to account.
7. The manner in which Board members, particularly non executives are appointed to be more transparent, possibly elected non executives could be looked at for such key positions.

**Care Quality Commission**

8. The CQC to establish a formal reporting system for all whistleblowing concerns raised within NHS providers and other NHS organisations (including national bodies). To be published annually as an anonymised report listing employers.
9. CQC inspections to include an interview with each whistleblower one year after they have raised concern to audit their treatment subsequent to raising a concern, and publish the outcome of these audits.
10. 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.

11. Monitoring of bullying complaints by CQC in any organisation where whistleblowing complaints refer to bullying or where reported bullying by staff and managers is in bottom 20%.

12. CQC to require NHS employers to provide an analysis by “protected characteristic” of all referrals to the CQC and all whistleblowing complaints to be published annually.

**NHS employers**

13. Board meetings to start with a patient story and a concern raised by staff and time given to considering what actions need taking.

14. Medical directors and nursing directors to ensure that a culture of openness and transparency encourages concerns to be raised early, and to be ultimately responsible for the clinical safety of their organisation.

15. Each Trust to draft a list of expected behaviours around openness, transparency and bullying – “ever events” – rather than simply a list of behaviours that might trigger disciplinary action.

16. Training on how to recognise bullying and respond to it as part of all induction, alongside moving and handling, and fire safety.

17. Training on how to raise concerns and what support is available to frontline staff at all levels to be provided to all staff. A prominent notice explaining how staff are expected to raise concerns to sited in every ward, department, and office.

18. Any medical director to have been found complicit in attempting to gag a member of the medical staff to be referred to the GMC.

19. Any nursing director to have been found complicit in attempting to gag a member of the nursing staff to be referred to the NMC.

20. Trust and other provider quality accounts to include anonymised details on all whistleblowing concerns. Quality accounts to be emailed to all staff. Any organisations found to have not openly disclosed whistleblowing concerns to be
held to more scrutiny and possibly the Chief executive replaced if the culture is found to be oppressive.

21. NHS staff survey reports for each employer to be sent to each member of staff highlighting outcomes relating to (a) bullying and harassment (b) reports on concerns raised, and asking for feedback. Feedback could be sent externally.

22. Any independent investigation report to be published on the Trust website and a copy given to any employee within the department involved. Names of individual staff can be redacted but the report should not be edited by the Trust.

23. A cap to be placed on the amount of legal fees that may be expended on any one whistleblowing case. All legal costs in any case where an ET is lodged to be declared annually by each Trust.

24. Examples of concerns raised actions taken and how staff have improved the service in question. Can be anonymised but in an open culture one might expect there to be named positive feedback given.

25. Annual award for the member of staff who raised a concern that was the most significant in making improvements for patients, judged by a patient panel.

**NHS staff survey**

26. Confirmation that any private contractor undertaking NHS work will be included in the next NHS staff survey and their results to be declared by employer

27. Locum staff should also be able to complete the staff survey.

**NHS England**

28. Any chief exec who is shown to have victimised a whistleblower to be removed from fit to practice list and suspended pending investigation

29. Any member of NHS England found to have been involved in suppressing patient safety information to be dismissed.

30. Whistleblowers and patient advocates to be encouraged to have a direct role in management training nationally and locally

**Regulators**

31. Professional regulators (GMC, NMC, HCPC) to explicitly support whistleblowers and to make clear that anyone, including managers, who fail to uphold the
appropriate Code of Conduct or organise or colludes in the obstruction or victimisation of those raising concerns will be investigated

32. Professional regulators to make clear the expectation of when it is appropriate – and when not appropriate to refer to them

33. Service regulators (CQC, Ofsted, HSE) to be expected to support whistleblowers and hold those who obstruct, bully or victimise them to account and to set out how they proactively do so

34. Quality accounts must record all whistleblowing cases, outcome, and what happened to whistleblowers

35. CQC, DH, NMC and GMC and HCPC should publicly report, by employer and Board the summary nature of the concern of all PIDA claims referred to them for advice or action
Appendix 1: Specific concerns about the NHS Employers guidance “The use of compromise agreements and confidentiality clauses” (2013)


Note that the extracts in bold are from the NHS employers guidance. The comments not in bold are our response to the Guidance.

P.1. Any such clauses should not be confused with the use of confidentiality clauses often included in compromise agreements which support both parties to move on after a dispute or where sensitive or personal information is involved.

They may do that in some circumstances but they can equally be used to “pay people off”. Whilst there may well be circumstances where “confidentiality” in respect of the identity of the individual might apply, there is no good reason why a blanket term of confidentiality should apply in ways that would prevent monitoring to identify patterns that would assist good practice to which might be helpful to regulators.

For example, where there is a breakdown of trust on confidence, or where a member of staff is receiving compensation for bullying or harassment it may be good practice that the name of the individual is not publicised. It is harder to see why the fact of a settlement, the fact that the settlement was after an ET1 was lodged.

P.1. While the information in this document is not intended to provide legal advice, it has been produced with legal input from Capsticks LLP

Patients First is aware of gagging clauses that Capsticks were directly involved in drafting. They have no demonstrable commitment to openness and transparency. We can share several examples where the CA contains no mention of the protected disclosure that triggered the events leading to a CA. Equally common

P.2. It is therefore essential that you seek legal advice before agreeing a compromise agreement with an employee.

Assumes a level playing field. Normal for TU members to be told “accept the offer, it’s the best there will be, if you don’t, we’ll have to consider pulling out” which might be OK if the member had confidence in the official and the lawyer, but often they don’t because they have both allowed the public interest dispute to be turned into a narrow employment one.
P.3. In cases where trust and confidence has irretrievably broken down, it can be mutually agreed that a termination of employment would be in everyone’s best interest.

That may be the case but it may also be very unjust and leave the originating issue unresolved and the member of staffing effectively signing under duress because of the alternatives to signing.

P.3. Compromise agreements should not be used to short-cut any investigations in relation to patient safety or care. It is therefore essential that they are not considered in isolation and employers ensure that they are aligned with processes and procedures relating to making referrals to professional bodies and safeguarding patients.

But we know they repeatedly are. We also know that so many employers misuse professional referrals that the NMC has had to decide how to respond to this and whilst the GMC says this is hard to identify we don’t believe it is. One simple question is needed – did the referral to the professional body precede or follow a protected disclosure. If the latter it is very likely retaliation.

P.4.

1. **Clauses which cover the terms of that agreement - for example, prohibiting any parties concerned from reporting the detail about the terms of the separation.**

   May be OK

2. **Clauses which protect confidential information gained by the employee as part of their employment, such as business-sensitive data or patient records. It is important to outline to all staff, their responsibilities to comply with the Data Protection Act 1998 and confidentiality within their terms and conditions of employment.**

   **Not OK** if such information needed to pursue public interest concerns so there should be an explicit exemption for these purposes

3. **Clauses against derogatory comments being made which prevents the employee from making vexatious, disparaging or derogatory comments about the organisation and its staff. In such cases, there is usually a**
mutual clause which also prevents the organisation from making disparaging or derogatory comments about the employee.

All depends what these words mean. If such clause is to be included it should explicitly bind all employees of the employer in the same way, including in relation to references

P.5. For the avoidance of doubt, nothing in this Agreement shall prejudice any rights that the Employee has or may have under the Public Interest Disclosure Act 1998 and/or any obligations that the Employee has or may have to raise concerns about patient safety and care with regulatory or other appropriate statutory bodies pursuant to his or her professional and ethical obligations including those obligations set out in guidance issued by regulatory or other appropriate statutory bodies from time to time.

This is fine but meaningless unless whistleblower can taken evidence and data with them, subject to assurances that that is the only purpose they will be used for

P.5. The HM Treasury template included in our severance payment guidance has been updated to include a section where you confirm that any compromise agreement or undertakings about confidentiality leave severance transactions open to adequate public scrutiny.

But this guidance does not address those circumstances where whistleblowers are offered payments which happen to equate to redundancy entitlements (though there is no redundancy) or where early retirement is agreed (where it would not normally be) as means of avoiding scrutiny. We know this goes on.

P.5. • There is no duty to provide a reference to an employee (except in certain sectors of activity such as the financial services sector). However, any reference provided must in substance be true, accurate and fair. You have a duty of care not only to your ex-employee but also to future employers. This includes where an agreed reference is provided as one of the terms of a compromise agreement.

Agree, but it is very common indeed for “informal” telephone references to undermine written references. It is also the case that bullying or incompetent staff are provided with flattering references to “move them on” with no consequences for those providing them.

P.6. Individuals who have suffered a detriment for raising a protected concern under the Act can take their employer to an employment tribunal. Where they have lost their job because of raising a protected concern, they could be fully compensated for their losses; the limit to any compensation awarded is uncapped. Awards for detriment short of dismissal (eg, being passed over for
promotion) will also be uncapped and will be based on what is deemed just and equitable in all the circumstances.

The likelihood of this happening is so slim as to be extremely rare both because of the obstacles to getting to court and the narrow view courts often take of PIDA claims if they are ever heard.

P.7. This statute means that it is unlawful for any employer to subject a worker to a detriment where they have made a protected disclosure. This is also very likely to extend to clauses inserted into compromise agreements which are aimed at preventing an employee from making a post-termination protected disclosure.

None should sure exist?

P.7. The Government made an announcement on 22 February 2013 proposing amendments to the Enterprise and Regulatory Reform Bill, which are targeted at strengthening existing protections for staff who raise a concern in the public interest. The amendments which were laid before Parliament on 26 February, will, if approved:

- extend employer accountability where staff are subjected to bullying or harassment from co-workers as a result of them reporting a concern. Currently, the law only provides protection where bullying and harassment comes from the employer.

No acknowledgement here that it was an NHS employer, whose CEO has since been promoted, who narrowed the law. Not any proposal to ensure Fecitt and co have their sanctions withdrawn.

- provide a defence for those employers who can demonstrate that they have taken all reasonable steps to prevent any such victimisation against those who speak up.

What does this mean? It will be turned into a let out clause. Sure each Trust board should announce zero tolerance for any such victimisation with it being gross misconduct?

P.7. contd.

- make a change in the name of compromise agreements to "settlement" agreements; and
• introduce a change in the law to make offers of settlement in relation to
termination of employment inadmissible in employment tribunal claims,
providing there has been no improper behaviour in the process of discussing
the agreement. This change in law has come about because of the current
uncertainty around whether or not discussions, that take place at the end of the
employment relationship, can be relied upon where it is unknown whether
there is an existing dispute between the employer and employee.

This risks being another opportunity for staff to be cajoled into signing a deal at all costs
without any allowable audit trail.

P.10. Model clause
Confidentiality

a. [he/she] has not divulged and shall not divulge to any person whatsoever
the fact of, negotiation and/or terms of this Agreement;

We believe it is in the public interest that anonymised data on the existence of
compromise agreements, whether they originated with a PIDA claim, and the amounts
paid should be disclosed, as a matter of course, to regulators.

b. in accordance with [his/her] common law duties and [his/her]
contractual duties under the Contract of Employment [he/she] will not
disclose to any person (except as required by law) any Confidential
Information concerning any matter relating to the business or affairs of
the Employer or its directors, officers, agents, employees or patients
which Confidential Information has been acquired by the Employee in the
course of [his/her] employment unless such information comes into the
public domain otherwise than by a breach of confidence on the part of
the Employee; and

We believe this clause should contain a clause explicitly making disclosure of PIDA
protected documents protected disclosures post termination

c. that [he/she] will not make or publish any untrue, disparaging,
misleading or derogatory statements about matters concerning the
Employer, its directors, officers or employees and/or take part in any
conduct conducive or potentially conducive to bringing the Employer, its
directors, officers, agents or employees into disrepute.

1.2. The Employer shall use its reasonable endeavours to ensure that its
directors, officers, agents and employees shall not divulge the fact of,
negotiation, nature and/or terms of the Agreement except to its professional advisers in connection with the conclusion of this Agreement or where required by any competent authority or Court of Law or HM Revenue & Customs or as otherwise required by law.

Putting to one side the potentially unclear nature of such phraseology, it is entirely unclear why the requirements on the employee are absolute whereas those upon the employers refer to "reasonable endeavours, given the far greater power residing with the employer.

General comments.

We have more general concerns about this advice.

1. It remains unclear what the consequences are for any employer who subjects a whistleblower to detriment. Detriment to a whistleblower should be explicitly linked to the duty of candour.

2. It is unclear why NHS employers cannot make join with PF in seeking Ministerial assurance that there are under all circumstances:
   a. Such protection is retrospective
   b. Such protection applies in any employer providing NHS services, whether private or not
   c. Same sanctions will apply to non NHS employers as to NHS employers

3. Is it now clear what the position of healthcare students on placement is since their victimisation certainly takes place?
Appendix 2: Extract from evidence of Frances Blunden to the Francis Inquiry

Witness Name: Frances Blunden
Statement No: First
Exhibits: FB1 to FB7
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Draft Witness Statement of Frances Blunden

I, Frances Blunden of the NHS Confederation, [address] will say as follows:-

1. I am currently employed as a Senior Policy Manager for the NHS Confederation ("the Confederation"). I have worked in this role for over two years. Prior to joining the Confederation in February 2008, I worked in various capacities as a Policy Adviser on health issues, my previous role being the Principal Policy Adviser at Which?
environment within the NHS is one where a culture of bullying is prevalent, and therefore I think it has limited effectiveness.

73. There has been an article recently published in the British Medical Journal ("BMJ") stating that whistle blowing can work in some circumstances and discussing peoples' different experiences of the process. I believe we need to have the process there, but I think we need to recognise that its effectiveness is limited. Whistleblowing complaints should be treated as the tip of the iceberg of complaints, in that the ones that actually come through are merely representative of a whole raft of others that never get reported and therefore remain under the surface. The National Audit Office recently published a report about the number of people who had raised a complaint in this way, and it confirmed that this is broadly the case.

74. Whilst whistle blowing policies do need to be place, it is quite clear that historically people never take this up because of the culture of fear. The Nursing and Midwifery Council ("NMC") are currently looking at doing something whereby they use all of the information they gather to pick up problem areas such as these. They are also intending to issue guidance in a similar way to the GMC in terms of their giving guidance to doctors acting as managers. It needs to be reiterated that staff have a professional responsibility to ensure quality of care and can still be held to account. In my view, it probably needs more people to be held accountable. Other than Bristol Royal Infirmary, very few clinicians have been held to account for their behaviour or failures. In my view, the Medical Director or Nursing Director also has a key role in reinforcing this and in shaping the culture of the workforce as a whole.

Assisting the Inquiry