**NHS Leadership, Performance and Patient Safety Review**

**Introduction**

I am presenting this evidence and the suggestions for improvement to patient safety as chair of the APPG for All-Party Parliamentary Group on Whistleblowing.

The APPG has drafted a legislative change to whistleblowing with a Private Members Bill - the Whistleblowing Bill (presented to Parliament on 4th January 2024). In doing so, we have given in depth scrutiny to the functioning of leadership, performance and patient safety in the NHS which I hope will be helpful to your inquiry.

From the outset, the healthcare sector and the NHS have been the most prolific contributors to our calls to evidence. We heard reports of NHS workers cowed by a ‘culture of fear’ that is driven from the top. They expect to be disbelieved, to be ostracised, put on leave, and most of all, afraid of counter allegations about their practice and referral to their professional body. Many find themselves in disciplinary hearings and employment tribunals. It is estimated that these cost the taxpayer many millions of pounds every year, but the true cost is unknown as the data is not available.

The APPG has conducted an extensive call to evidence about the effectiveness of the UK’s whistleblowing framework. More than 50% of respondents have come from the healthcare sector. The single most significant finding was a failure by senior leaders to understand who a whistleblower is, what whistleblowing is, and what their responsibilities as employers are. It is this work that helped persuade the Government to undertake a review of the UK’s Whistleblowing Framework[[1]](#endnote-1), the result of which is due imminently.

Whistleblowers are routinely subjected to allegations relating to their conduct or capability, and the concerns they raise are subject to flawed or sham investigations. Few of these allegations, or those referred to professional bodies, come to anything and the majority are dismissed. However, we have been told that these tactics often have a chilling effect on whistleblowers who lose confidence in the NHS and seek alternative employment or leave the profession altogether.

Our research and findings, which informs this document, can be found on our website [www.appgwhistleblowing.co.uk](http://www.appgwhistleblowing.co.uk).

It is these findings that shaped the proposals contained in Whistleblowing Bill and form the basis for the recommendations that I make to this committee.

The proposals in the Bill would address the questions being asked here, in that it tackles the key issues that exacerbate patient safety concerns, including uniformity of policy, procedure and reporting platforms, the simplification and standardisation of the language used to identify whistleblowing, the mechanisms to protect whistleblowers and the integrity and comprehensive investigation of allegations relating to patient safety. The proposals also seek to address transparency and accountability in relation to leadership and the management of whistleblowing about serious patient safety. The Bill proposes that the solution can be administered by one central Office of the Whistleblower, which will have statutory powers to set standards, uphold and enforce the regulations and provide a central communication function to inform and educate the public and the NHS.

**Q.1. How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this.**

Evidence provided to the APPG suggests there is an overwhelming absence of confidence in NHS leadership, or confidence in the whistleblowing framework which is supposed to protect staff from retaliation.

The APPG heard evidence from staff who attempted to report concerns at the Countess of Chester Hospital who themselves became victims of a senior management intent on closing down concerns. The conduct of senior managers was described as, “*underhand and dishonest*”.

This is not an isolated incident. Patient safety is routinely relegated to protect the reputation of, not only the hospital or trust, but also the board and senior managers. People that we have spoken to are fully aware of their duties and expectations as a medical professional, but that there are often fears of a negative reception from management if they speak up.

Staff reported a lack of confidence in written policies and procedures and believe them to often be nothing more than a ‘tick box exercise’.

Meanwhile, when senior managers were asked by the APPG to explain their understanding of whistleblowing, including the definition of whistleblowing, we felt they demonstrated an absence of knowledge or understanding of policy and procedure, or their role as a prescribed person. We feel that this lack of clear understanding at the top may be indicative of why so many opportunities to prevent harm to patients and retain good staff are missed.

**Recommendations for Boards and Senior Leadership Teams:**

* Every board member should undergo mandatory and comprehensive training about whistleblowing and receiving whistleblowing concerns. Whistleblowing and raising ‘Patient Safety concerns’ are one and the same thing and this should be embedded into the central policy.
* Whistleblowing should be a fixed agenda item and hospitals should appoint an independent member to ensure that governance is sufficiently robust, tested and enforced.
* A Whistleblowing Champion should be responsible for design, development and implementation of policies, procedures and reporting platforms. That the framework is regularly tested and evaluated. KPI’s should include measurements of staff awareness and confidence to use the framework.
* Board members should engage in “mystery shopping” and seek random feedback from patients and families.
* Boards should be responsible for ensuring that it is satisfied that every whistleblowing allegation is properly investigated by independent and professional investigators.
* Boards should set up a process to review and take feedback from people who have used the whistleblowing policy to report patient safety issues and also investigate when whistleblowers have been subjected to disciplinary action.
* Boards should review litigation and look to identify patterns of behaviour. This would have been an early indicator that something was wrong at the Countess of Chester and could have prevented the murder of babies.
* Boards should introduce a system that monitors the career and performance of whistleblowers over their career to identify the impact of whistleblowing on careers.
* Boards should publish good news stories which result from acting on whistleblower intelligence.
* Boards should introduce recognition schemes for whistleblowers.
* Boards should publish the full cost of whistleblowing cases including litigation, investigation and associated staffing including back filling posts when whistleblowers are absent for reasons related to their whistleblowing.
* The NHS should introduce a centralised system that requires every board to register all reports that are made using whistleblowing policy AND those where they identify that the whistleblowing policy should have used.

**Q.2. What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?**

The Kark review was a well-received and sensible attempt to raise standards within NHS leadership, particularly with respect to patient safety and safeguarding. However, the absence of any statutory obligations appears to not have led to improvement. Evidence indicates that this report confirmed what many staff believed and had a chilling effect.

There are many examples of a daily downturn in the treatment of whistleblowers who increasingly turn to alternative careers or turn the other way to avoid what might be years of retaliation and litigation in which they lose everything. For example, Newcastle’s NHS Trust has been subjected to an inspection by the regulator following shocking reports of abuse. These reports included claims that bullying is described as “the norm”, clinical correspondence unsent, whistleblowers punished and reports of sexual and physical abuse go unchallenged. The leadership at this Trust (which had previously been rated “outstanding”) was criticised by the CQC in its recent inspection and it has been downgraded to “inadequate”.

This is not an isolated case and there is evidence of a disconnect between recommendations and mandated actions which continues to sit at the heart of the failure to protect patients from harm.

Q.3. **How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?**

Career healthcare workers that we spoke to have reported no noticeable changes in leadership standards and culture. It is worth noting that, in the aftermath of the Bristol baby scandal of the late 1990s (in which it was calculated that up to 170 babies died that might otherwise have lived), the government’s response was,

"*Bristol was a turning point in the history of the NHS. We are determined that some good can come from the tragedy that took place there*".

The failings that resulted in so many avoidable deaths over 25 years ago remain central to every NHS scandal. Repeated inquiries have exposed identical failings and almost identical recommendations, but avoidable deaths continue to hit the headlines - not because of an absence of reports, but because of the absence of a robust and trusted whistleblowing framework across the NHS.

**Q.4. How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?**

In an environment where managers have an increasing influence over clinical care and standards, and where, for example, decisions about staffing levels may carry life-and-death implications, it would be appropriate to introduce proper and rigorous mechanism for holding NHS managers and executives to account for their decisions. Arguably, managers are contractually obliged to conduct themselves with candour, however, as evidenced by continuing stories of cover up, there needs to be substantially greater transparency and accountability.

Currently, we have been unable to identify a formal mechanism for recording poor behaviour including, prejudice and abuse exemplified by bullying, victimisation and harassment. We have seen evidence of managers at the heart of serious wrongdoing being promoted. Rewarding poor performance puts patients and staff at risk.

The APPG, in principle, supports calls for the professional registration of managers as a means of improving standards of patient safety and ending the revolving door that allows managers who have been implicated in covering up or bullying to move on without consequence.

**Q.5. How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?**

The well publicised treatment of NHS whistleblowers will have had an effect on anyone who is considering raising patient safety concerns. The APPG has consulted with whistleblowers, regulators and senior leaders in the NHS who have shared they have little confidence in the whistleblowing framework and would not use it themselves. The evidence overwhelmingly demonstrates an often confused and frequently hostile approach to whistleblowers despite excellent policies and procedures. The APPG has been told by senior executives and managers that whistleblowing is ‘career suicide’.

Evidence presented to the APPG shows that staff feel reluctant to speak up and have little confidence that concerns will be acted on and the situation is only deteriorating. Whistleblowers report that raising serious patient safety concerns is likely to result in them becoming the target of retaliation as managers do not want to have to deal with the misconduct of their own colleagues.

We are finding that whistleblowers are increasingly turning to MPs and the APPG in an attempt to report concerns anonymously. Many are desperate and afraid of the consequences of losing their job and the majority cite the conduct of senior leaders as the root cause of the problem.

Reports suggest that senior leaders and the management chain often do not understand the law and obligations of an employer or recognise that they are prescribed persons under the legislation. We believe that the language used in existing legislation, now 26 years old, is central to these problems. This is compounded by the adoption of a myriad of different policies and procedures across the NHS that does not refer to whistleblowing but, ‘speaking up’ or ‘raising concerns’. Many whistleblowing cases have been dismissed as grievances in a perceived attempt to dilute the seriousness of patient safety concerns affecting the public to a dispute between parties.

Research conducted by WhistleblowersUK found over 90 different reporting mechanisms, policies, and procedures. Many fail to reflect the law or resemble a cohesive overarching policy. This disadvantages whistleblowers and literally creates obstacles that are impassable for all but the most tenacious staff, but more importantly disadvantages patients and must be held, at least in part, accountable for many of the catastrophic failures across the NHS.

This confused and disjointed approach to whistleblowing has contributed to avoidable deaths and life changing injury as reported by Dr Bill Kirkup and Donna Ockenden. There can be no doubt that ignoring or suppressing whistleblowers can result in avoidable harm.

When challenged, we found that some senior NHS professionals were unfamiliar with local policy and procedures, the law or their rights as whistleblowers. We feel this demonstrates an overarching absence of governance.

We heard that managers have used the threat of reporting to the GMC and NMC to intimidate staff. The Hospital Consultants and Specialists Association have recently published a survey suggesting that 71% of their members believed that it wasn’t possible to raise patient safety concerns without harming their careers, and of those who had spoken up in the past, 93% said they weren’t satisfied with the response from management.

This evidence is corroborated by the Freedom to Speak Up Guardian Dr Jayne Chidgey-Clark who in her January newsletter referenced the ***“fear and futility***” felt by workers across the NHS in relation to speaking up.

Much of the background information in answer to this question is contained in the footnotes.

The introduction of “Freedom to Speak Up”, a recommendation of Sir Robert Francis’s 2015 report, has driven significant improvements. However, evidence provided on this scheme to the APPG demonstrated support for an Office with real teeth and statutory powers to protect whistleblowers and stimulate cultural reform. Many of the Local Guardians are part time and have inbuilt conflicts as they are employed by the hospitals. Indeed, we have heard from several local Guardians of their experience of supporting whistleblowers only to become one themselves.

Suggestions for improvement would be a three-tier approach to NHS leadership in respect of whistleblowing.

1. Executives and NHS leaders must themselves be incentivised to and recognised for changing the culture to one which welcomes a safety-first philosophy and which recognises the utility and cost-effectiveness of whistleblowing.

2. The NHS leadership must be accountable to an Independent regulator (The APPG recommends an Office of the Whistleblower) responsible for setting standards of corporate behaviour and equipped with the necessary sanctions to enforce proper ethical, moral and appropriate safety standards, including the duty of care and candour.

3. Whistleblowers should be given much greater support in law, with legislative changes to ensure that they are protected before detriments, punishments and job losses commence, make sure that their concerns are promptly addressed and that the public interest and safety is prioritised, and ensure that any unfairly treated whistleblowers can obtain redress. Finally, the law should be robustly enhanced so that those NHS leaders who might cover-up acts of detriment to patients and who attempt to silence whistleblowers can be held to account, if necessary, by making the malicious targeting of whistleblowers a criminal offence.

4. Review and revise how targets are set and the performance management frameworks as these have been seen to drive a blame and hide culture.

**Q.6. How could investigations into whistleblowing complaints be improved?**

We believe the single most effective way to improve investigations into whistleblowing is to take the investigations out of NHS responsibility and oversight, and instead create a system which provides for rigorous and, crucially, independent, impartial investigation.

The APPG’s secretariat WhistleblowersUK frequently witnesses the flaws in investigations, through Employment Tribunals. These typically include bias and conjecture disguised as findings of fact. In many cases it is safe to say that the report was written before the any witness statement was given and the Secretariat reports evidence of cutting and pasting of statements.

In over half a century, things have not changed. The case of Dr Peter Duffy exposed how investigations into the people who raise patient safety concerns contain a pre-determined outcome, directed and funded by the NHS. His report was co-written by an NHS employee and finally approved and signed off by the NHS prior to publication.

It is the APPG’s recommendation that any future NHS whistleblower investigations be independent and run by accredited, professional investigators and that sanctions and penalties to applied to both individuals and organisations who withhold or fabricate evidence.

In this context, the proposed “Office for the Whistleblower”, as proposed by the APPG’s Bill, will level the playing field providing robust oversight and where necessary immediate intervention to prevent harm to patients.

**Q.7. How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha’s Rule?**

For measures such as Martha’s Rule to be effective, the NHS must transform its attitude and management of whistleblowing and the implementation of a ‘learn not blame’ culture.

Evidence has suggested that the NHS complaints system is not performing as intended to investigate, provide adequate redress or improve safety. Despite the Statutory Duty of Candour and requirements relating to disclosure, harmed patients and bereaved relatives face too many hurdles and it can take many years to settle claims and reach resolution.

Martha’s Rule should improve patient safety and is to be welcomed. That said, obtaining a second opinion is not always as easy as it sounds, especially in small units where there is only one team, or overnight or at the weekend when, typically, there is only one team on-call. However, it certainly increases the power and leverage of patients and/or relatives in situations where care may be suboptimal and therefore is a step in the right direction.

**Q.8. What can the NHS learn from the leadership culture in other safety-critical sectors e.g. aviation, nuclear?**

The aviation sector operates a ‘no blame’ culture when it comes to safety. Its ‘Speak up Culture’ is embedded in safety practice across aviation and actively encourages speaking up. Failure to speak up in relation to a safety concern can result in (potential) penalties.

The aviation industry recognises that whistleblowing or speaking up is critical to safety. However, evidence from whistleblowers suggests that the sector is not always as successful when it comes to dealing with issues that do not relate to airworthiness of its stock.

Since meeting with the APPG, the CAA have adopted improvements to its reporting process; improved access, platforms and helplines and improvements to ensure anonymity and confidentiality.

The conclusion from the evidence that we have examined between these sectors and healthcare is that whistleblowers are welcomed and respected when they alert a serious national or international critical incident but may be unwelcome at local levels where there is a perception of reputational damage.

A culture of fear is embedded within the NHS - reinforced by the many high-profile cases currently going through the Employment Tribunals.[[2]](#endnote-2)

**Additional Explanatory Information**

The APPG for Whistleblowing is conducting an ongoing call to evidence and as part of this, brought together some of the most senior leaders representing the NHS, National Guardians, Unions, Investigators and Regulators in March 2023. The evidence provided corroborated the evidence provided by hundreds of NHS whistleblowers about the treatment of those raising serious patient safety concerns, and the treatment of the concerns.

It was widely felt that there are too many barriers and obstacles within the NHS to make speaking up policy and procedures effective and that the law as it stands is not fit for purpose.

Overall, NHS whistleblowers still felt they were not treated with appropriate respect when they made their disclosures. Furthermore, they reported that the systems appeared to be designed to obstruct rather than encourage concerns from being heard, and that the reputation of the Trust was, too often, more important than a serious patient safety concern.

NHS whistleblowers often reluctantly enter into litigation as a last ditch effort to protect the public from harm. They expect vindication and restitution from the Employment Tribunal after exhausting every other avenue. Most whistleblowers report having raised their serious patient safety and other concerns with multiple people and agencies.

Numerous whistleblowers that we have spoken to expected the Employment Tribunal to hear their evidence and take action on the issue raised, only to discover that this is not within the scope of the Tribunal.

Across society very few people understand that it is outside of the scope of the ET to act upon evidence of serious patient safety. Even after upholding of the reasonable belief of a ‘Protected Disclosure’ (e.g. serious harm to patients) the ET takes no action beyond an award of compensation for the loss to the whistleblower.

The objective of Public Interest Disclosure Act 1998 (PIDA) claims are to determine whether a whistleblower has been subjected to detriment that can be directly attributable to their whistleblowing.

The existing legislation reduces serious patient safety concerns to an employment dispute and compensation. It does not deal with, or address, evidence or allegations of harm to the public as the Employment Tribunal itself is not set up to conduct these investigations.

This report has been put together by WhistleblowersUK on behalf of the APPG for Whistleblowing.

Reference Material

1. https://www.gov.uk/government/publications/review-of-the-whistleblowing-framework/review-of-the-whistleblowing-framework-terms-of-reference [↑](#endnote-ref-1)
2. <https://davidhencke.com/2023/12/07/death-in-ward-22-whistleblower-nurse-raises-patient-safety-issues-in-the-same-hospital-where-dr-chris-day-is-fighting-avoidable-deaths/> [↑](#endnote-ref-2)