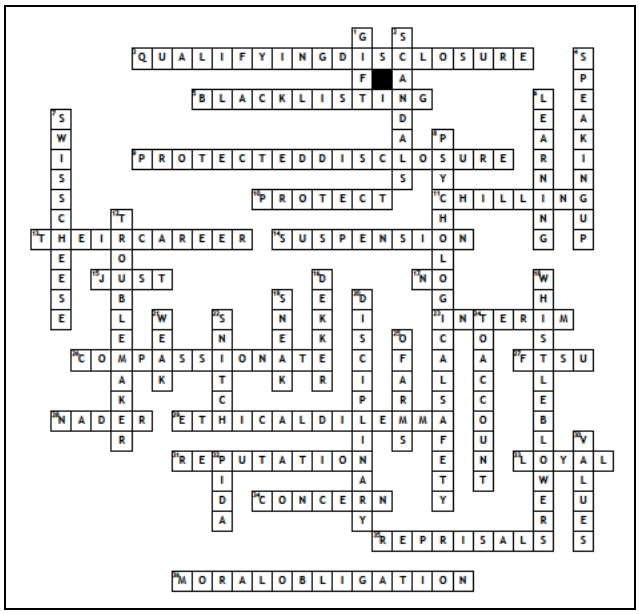
Notes on the solution to Crossword Counterpoint: glimpses of NHS whistleblowing terrain



Context

The **Crossword Counterpoint: Glimpses of NHS whistleblowing terrain** and clues were published on the hub on 16 March 2022.[1] The Solution was published on 29 April 2022.[2] These explanatory notes expand on the answers to each clue.

This document is work-in-progress. I plan to complete it during spring 2022, depending on other calls on my time. The following list of answers contain clickable links to the corresponding clue and notes.

Lest it need be said, this does not constitute legal advice. However, if anyone spots anything which is not correct, or would like to make comments of any sort, I would welcome discussion, in a spirit of learning and continuous improvement.

Solution

Across

28 across:	NADER	20
29 across:	ETHICALDILEMMA	21
31 across:	REPUTATION	21
33 across:	LOYAL	22
34 across:	CONCERN	26
35 across:	REPRISALS	
36 across:	MORALOBLIGATION	

Down

1 down:	GIFT
2 down:	SCANDALS
4 down:	SPEAKINGUP
6 down:	LEARNING
7 down:	SWISSCHEESE
8 down:	PSYCHOLOGICALSAFETY
12 down:	TROUBLEMAKER
16 down:	DEKKER
18 down:	WHISTLEBLOWERS
19 down:	SNEAK
20 down:	DISCIPLINARY
21 down:	WEAK
22 down:	SNITCH
24 down:	TOACCOUNT
25 down:	OFARMS
30 down:	VALUES
32 down:	PIDA

Across

3 Clue: *Legal term for (loosely speaking) a concern related to: danger to health or safety; cover up; criminal offence; failure to comply with legal obligation; environmental damage; or miscarriage of justice - raised by a worker who has a reasonable belief that raising it is in the public interest (10,10)*

Answer: **QUALIFYINGDISCLOSURE**

The UK government website states clearly that whistleblowers are protected by law:

> *As a whistleblower you're protected by law - you should not be treated unfairly or lose your job because you 'blow the whistle'.*[3]

The legislation which, in theory (if not in practice) is supposed to protect whistleblowers is the *Employment Rights Act 1996* (ERA). The ERA has been amended, principally by the *Public Interest Disclosure Act 1998* (PIDA). The ERA defines strict criteria for who it purports to protect. Section 43B of the ERA defines what it terms a **qualifying disclosure**:[4]

> *A "**qualifying disclosure**" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—*

(a) that a criminal offence has been committed, is being committed or is likely to be committed,
(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
(c) that a miscarriage of justice has occurred, is occurring or is likely to occur,
(d) that the health or safety of any individual has been, is being or is likely to be endangered,
(e) that the environment has been, is being or is likely to be damaged, or
(f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

Section 43B goes on to add further detail as to which disclosures qualify for protection. Further criteria have to be satisfied before a '*qualifying disclosure*' becomes a '*protected disclosure*' (see notes below for 9 Across).

5 Clue: *Unofficial process in which whistleblowers are debarred from employment in their chosen field* (12)

Answer: **BLACKLISTING**

In practice, many whistleblowers find that they are effectively 'blacklisted' from future employment, even if they have been found to have been unfairly dismissed and their concerns upheld. Despite such vindication, their former employers rarely if ever reinstate or reengage them, let alone apologise for their unfair actions. Many feel that this is an affront to natural justice.

If the whistleblower seeks to salvage their career by applying for posts in other NHS organisations they typically find that they are not even short-listed for vacancies for which they meet all criteria in the person specification. In some cases openings which they have been encouraged to pursue are subsequently blocked, without explanation. In other cases provisional offers of employment are mysteriously withdrawn. This exclusion compounds the original moral injury to staff who have been unfairly dismissed after speaking up.

It is hard to avoid the conclusion that staff who have been forced out of their job after speaking up are then blacklisted. This was acknowledged in the 2015 report of the ***Freedom To Speak Up*** **review**:

> *7.3.4 ... The NHS may be made up of a large number of separate employing organisations, but it is effectively a monopoly employer in many fields. This applies most particularly to clinical staff with specialist skills where the number of job opportunities are limited and the networks are strong. A non-consensual or disputed termination of employment in one part of the system often leads to exclusion from every other part, regardless of whether there is any genuine justification for this.* [5, p.152]
>
> *7.3.5 We heard from and met a number of people who were struggling to get alternative employment and were concerned that they may have been blacklisted. While the Government has taken action to deal with blacklisting relating to trade union activity, this does not address the behaviour of recruiting organisations who may, for example, have heard via the media or 'grapevine' that an applicant is a whistleblower.* [5, p.152]
>
> *7.3.6 Quite apart from the impact on individuals, most of whom were acting in good faith when raising a concern, there is a huge waste to the NHS if highly trained and skilled individuals leave the service. I consider that all NHS*

organisations have a moral responsibility to give every possible consideration to re-instating a member of staff who had genuine concerns and whose own performance is sound. [5, p.152]

This is particularly noteworthy in the context of massive workforce shortages of skilled healthcare professionals in the NHS. This shortage of crucial staff is a key factor in the current unacceptably long waiting times for many healthcare procedures. It is another aspect of the consequences of retaliation by some NHS organisations against staff who have spoken up.

The report of the ***Freedom To Speak Up*** **Review** recognizes that a history of having raised concerns should be seen as *'a positive characteristic in a potential employee'*. It puts on record recognition by the author of that report that '*the existing legislation under the Employment Rights Act 1996 and the Equalities Act 2010 do not give adequate redress to whistleblowers, either when they are in employment or when they are applying for new jobs*. [5, p.153]

The ***Freedom To Speak Up*** **Review** report states that *'supporting staff back into employment*' is *'Good practice'*. It gently suggests that employers should:

- *seek to reinstate staff who have spoken up, offering training, mediation and support where necessary*
- *make clear that they welcome job applications from people who have raised concerns at work to improve patient safety*
- *consider a history of having raised concerns as a positive characteristic in a potential employee.* [5, p.154]

Many NHS staff felt that this did not go nearly far enough. This has been reinforced by the passage of time since publication of the *Freedom To Speak Up* review in 2015. There are clear signs of an emerging evidence-based groundswell of opinion that the continuing mistreatment of NHS staff who have raised legitimate concerns - combined with related fear of speaking up and a sense of futility that speaking up would actually achieve anything - demand a new approach.

Employers are likely to deny any suggestion of blacklisting, and it can be very difficult if not impossible to prove. However, the lived experience of numerous whistleblowers whose employment has ended after raising concerns provides compelling evidence that they are seen as damaged goods by potential future employers. Their career in their chosen field has effectively been ended by speaking up.

9 Clue: *A qualifying disclosure which meets additional legal criteria relating to its content and method of disclosure* (9,10)

Answer: **PROTECTEDDISCLOSURE**

According to Blackstone's Employment Tribunals Handbook 2014-2015:[6]

> *"Whistleblowers are given protection under employment law in three ways. First, a worker may not be subjected to a detriment as a result of having made a protected disclosure. Second, an employee may not be dismissed as a result of having made a protected disclosure. Third, any provision in a contract purporting to prevent a worker from making a protected disclosure is void."*[6]

Section 43A of the ERA [7] defines a **protected disclosure** *as " a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H* ".

This means that even if a disclosure meets criteria for being a qualifying disclosure, whether or not the person disclosing it is 'protected' under UK legislation is determined by whether or not it has been made in compliance with one or more of the criteria given in sections 43C-43H of the *Employment Right Act 1996*.[8-14] See above, clue 3 Across, for notes about qualifying disclosures.

10 Clue: *Current name of charity formerly known as 'Public Concern At Work'* (7)

Answer: **PROTECT**

The self-styled *'UK's whistleblowing charity'* now known as ***Protect*** was originally known as *'Public Concern at Work'*. The charity was formed in 1993.[15]

11 Clue: *Adjective describing the effect on speaking up culture of retaliation against whistleblowers* (8)

Answer: **CHILLING**

A definition of '*chilling*' is **gravely disturbing or frightening**.[16] It is gravely disturbing if the culture within any organisation permits retaliation against staff who raise legitimate concerns in the public interest. Particularly so when the retaliation is perpetrated by NHS organisations against healthcare professionals and other conscientious employees who raise valid concerns about the safety and care of patients.

The 2015 report of the ***Freedom To Speak Up*** **Review** found clear evidence that retaliation against NHS whistleblowers exists.[5] It is important to understand that NHS 'whistleblowers' are typically conscientious, loyal members of staff who have spoken up, almost invariably internally within their organisations, usually directly to managers, in line with local and national policies and codes of conduct. In other words, those who are then subjected to retaliation have been penalised for doing their job.[17]

However, the consequences of retaliation against NHS whistleblowers extend well beyond the impact on individual members of staff upon whom such reprisals have been inflicted. Other employees realise that they cannot be sure that it is safe for them to speak up, even when they are well aware of poor practice that puts patients at risk of avoidable harm.

The latest **NHS England national staff survey results** (2021 survey) shows that only 62% said they felt safe to speak up about anything that concerned them in their organisation.[18] More than one quarter of staff were unable to say they would feel secure raising concerns about unsafe clinical practice.[19] These data demonstrate the chilling effect that retaliation against whistleblowers has on NHS staff perceptions as to whether it is safe for them to speak up.

The concept of a **chilling effect** is well-established in democracies which seek to uphold freedom of speech. It has been described as the negative effect of actions which result in dissuading people from exercising their rights or fulfilling their professional obligations, for fear of sanctions or consequences such as threats, attacks or smear campaigns.[20]

13 Clue: *One of the things which workers may put at risk if they speak up* (5,6)

Answer: **THEIRCAREER**

There is abundant evidence of NHS staff losing their careers, or suffering other substantial detriment to their reasonable expectations of career progression, after speaking up.

If the question arises, such staff typically report having previously unblemished employment records. In my experience of meeting with a good number of present and former NHS staff whose careers have been damaged after raising patient safety and related concerns, the vast majority have been highly credible healthcare professionals.

14 Clue: *Sadly, often the first stage of formal response by NHS managers and HR departments to staff who have raised patient safety and related concerns* (10)

Answer: **SUSPENSION**

Part of the wretchedly poor ways in which some NHS organisations have handled cases in which staff have raised valid concerns is their brutal and wasteful use of disciplinary action. Hypocritically this is often coupled with pious pretence that they support staff who speak up, and denial that the disciplinary action has anything to do with the fact that the staff concerned have raised valid concerns before the disciplinary action was instigated.

The first formal stage of disciplinary action is typically suspension, coupled with a Kafka-esque statement that '*suspension is a neutral act*'. This construct may fit in with an HR viewpoint which sees members of staff as 'resources', to be manipulated into playing roles in 'cases', but this is not the way that suspension is seen by others.

When staff are suspended in these circumstances they are generally given instructions not to contact colleagues. This is part of a deliberate process of isolating the whistleblower from support networks. It is difficult to see how this fits in with the compassionate culture which leaders say they want to create in the NHS.

NHS staff who are suspended after raising valid concerns are likely to be unprepared for it. It is likely to come as a body blow and be seen as an act of serious aggression. It taints their reputation in the eyes of others. There is more than a suggestion of it being done *"pour encourager les autres"*.[21]

There is a lot of job creation and empire building associated with what is sometimes called the whistleblowing industry. The motives of those who instigate disciplinary action need very careful scrutiny by people who have the intellectual ability, psychological insight, familiarity with the workplace setting, independence of thought and action, and understanding of power dynamics to understand what is really going on when NHS managers suspend staff who have spoken up about poor patient care.

The report of the ***Freedom To Speak Up*** **Review** recognizes that suspending NHS staff who have raised concerns is seriously problematic.[5] Its findings include the following extracts (my highlighting):

> **50** ***Suspensions*** *and special leave should only be used where there is a risk to patient or staff safety, or concern about criminal wrongdoing or tampering with the evidence.* (p.15)
>
> ***3.2.5*** *There were descriptions of what can only be described as a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation. Contributors explained how this could lead to:*
> - *physical and psychological exhaustion*

- *deterioration of emotional well-being and mental health such as chronic and recurring depression, anxiety, panic attacks and mental breakdown*
- *professional consequences such as detriment to professional standing and career progression*
- *impact on employment including **suspension** or dismissal and the resulting stigma plus possible blacklisting when seeking re-employment*
- *financial consequences, for example legal fees, and the impact these could have including, in some cases, people losing their homes.* (p.54)

3.2.48 *Organisations that support and represent whistleblowers reinforced and expanded on the issues identified above. Problems they highlighted included:*

- *a culture of fear*
- *victimisation after speaking up, for example intimidation and bullying and retaliatory referrals to professional bodies*
- *detriment after speaking up, for example professional, personal and financial well-being and, emotional and psychological detriment*
- *confusion over the definition of whistleblowing leading to misunderstandings about when a matter is whistleblowing, when the process starts and if an individual is protected*
- *concerns lost or 'contained' in middle management*
- *employers focused on the employment aspect rather than the patient safety issue*
- *lack of confidence in the investigation process. For example: restricting access to relevant documentation, tampering with evidence and fabricating allegations, conflicts of interest of investigators, editing reports ahead of publication or blocking their disclosure*
- *lack of feedback to those who have raised concern giving the perception that nothing is done and/or matters go unresolved*
- *absence of a level playing field between employers and whistleblowers in terms of access to finance and/or legal advice*
- *staff let down or unsupported by the relevant union*
- *HR departments not supporting whistleblowers or preventing detriment to them*
- *loss to the NHS of highly skilled and experienced staff due to ill health, **suspension** or termination of employment after raising a concern*
- *informal blacklisting of staff*
- *individuals and employers not held accountable for bullying behaviour or making unfair or unfounded allegations against whistleblowers*
- *a general lack of leadership.* (pp 63-64)

6.1.8 ***...*** *in terms of handling concerns:* (p.119)

...

- ***overuse of suspension***

...

6.5.4 *Whilst it is not possible to know the volume of suspensions that are, or are perceived to be, related to the raising of concerns, we heard from HR, management and staff that **suspension was overused**. The general view was that suspensions should be the last, not the first, option considered.* (p.130)

6.5.5 ... *A solicitor who worked for a number of sectors noted that **use of suspension was a particular issue in the NHS**.* (p.130)

> **6.5.11** *I am persuaded that* ***suspension is overused on staff who raise concerns****.* (p.131)
>
> **7.3.4 ...** *" The majority of doctors trapped in this situation [****suspension****] have great difficulty ever returning to clinical practice. As the NHS is a monopoly employer other avenues of employment are extremely limited."*(p.152)

I am aware of a case in which an NHS whistleblower was found by the Employment Tribunal to have been unfairly dismissed. During the tribunal his line manager proudly explained that she was *"an experienced suspender"*. In my mind her apparent assumption that this presented her in a good light starkly illustrates the problem. It conveys a very disturbing managerial mindset which is at the heart of the mishandling of whistleblower cases. In a similar anecdote I recall a young HR manager taking delight in describing herself as *"a rottweiler"*. Leaders should take a long hard look the systems that allow such attitudes, beliefs and behaviours to exist.

This is not an attack on all NHS managers and HR staff. However, good managers and HR professionals really do need to distinguish themselves from colleagues who exhibit such behaviours. If there is a place for disciplinary action in whistleblowing cases it should be taken against staff responsible for retaliation against staff who have raised valid concerns.

The ***Freedom To Speak Up Review*** report gives the following as examples of *'Good practice - Personal and organisational accountability*':

- *Discriminating against, or victimising, an NHS worker because they have raised a concern, or turning a blind eye when other officers or employees do so, is regarded as serious misconduct or mismanagement.*
- *Whistleblowing, employment and Human Resources policies are clear that victimisation, or allowing the victimisation by others, of someone because they have raised a concern will result in disciplinary action.* [5, p.208]

I agree, but has this ever happened?

—

P.S. I initially assumed that the answer to the above question ('*has this ever happened?'*) would probably turn out to be *'no'* (if anyone in the NHS could be persuaded to answer it) would be *'no'*. In that sense it was almost a rhetorical question. I have never come across an instance of anyone victimising an NHS worker because they have raised a concern, or allowing such victimisation by others, to be subjected as a result to disciplinary action.

However, on reflection the answer has to be *'yes'*. It (*disciplinary action*) has frequently been the result of victimisation (or allowing the victimisation) of someone because they have raised a concern. **The trouble is, the person who has had the disciplinary action taken against them has almost invariably been the person who has spoken up.**

I say *'almost invariably'*, but should this be *'invariably'*, without qualification? Many NHS staff who have spoken up have subsequently had disciplinary action taken against them. **Has there ever been a case in the NHS in which disciplinary action has been taken against the perpetrator(s) of victimisation of someone because they have raised a concern?**

Is this what the authors of the *Freedom To Speak Up* Review intended?

Do NHS leaders agree that taking disciplinary action against perpetrators of victimisation of someone because they have raised a concern would be consistent with *just culture*?

15 Clue: *A culture of trust, learning and accountability* (4)

Answer: **JUST**

Contents of this section on Just Culture (with hyperlinks)

Culture is a complex amalgam of beliefs, assumptions, attitudes, customs, practices, rituals, values and behaviours. It is often described as '*the way we do things round here*' (sometimes with the cynical addendum '*when no one is looking*'). It is increasingly recognized that organisations need to have a **just culture** which shapes organisational response when things go wrong - as they will in all organisations from time to time. Just culture is an important component of a healthy **safety culture**.

One of the recommended strategies of *Healthcare Excellence Canada* is to understand **patient safety culture** and its components. They identify just culture as an important component of patient safety culture. Patient safety culture is multi-dimensional, consisting of a number of features:[22]

- ***informed culture*** *– relevant safety information is collected, analyzed and actively disseminated*
- ***reporting culture*** *– an atmosphere where people have the confidence and feel safe to report safety concerns without fear of blame, and they trust that concerns will be acted upon*
- ***learning culture*** *– preventable patient safety incidents are seen as opportunities for learning and changes are made as a result*
- ***just culture*** *– the importance of fairly balancing an understanding of system failure with professional accountability*
- ***flexible culture*** *– people are capable of adapting effectively to changing demands*

Psychologist **James Reason** developed the concept of just culture in considering reporting culture within an organisation and different approaches to human error. He is the author of a 1997 book, *'Managing the risks of organizational accidents'*, from which the following extracts are taken.[23]

> *"An effective reporting culture depends, in turn, on how the organization handles blame and punishment. A 'no-blame' culture is neither feasible nor desirable. A small proportion of human unsafe acts are egregious (for example, substance abuse, reckless non-compliance, sabotage and so on) and warrant sanctions, severe ones in some cases. A blanket amnesty on all unsafe acts would lack credibility in the eyes of the workforce. More importantly it would be seen to oppose natural justice. What is needed is a* ***just culture****, an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information - but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour."*[23, extract from section entitled '*The components of a safety culture'*]
>
> *"While this book has strongly emphasized the situational and systemic factors leading to the catastrophic breakdown of hazardous technologies, it would be naïve not to recognize that, on some relatively rare occasions, accidents can happen as the result of the unreasonably reckless, negligent or even malevolent behaviour of particular individuals. ...*
>
> *"A pre-requisite for engineering a just culture is an agreed set of principles for drawing the line between acceptable and unacceptable actions. ... All human actions involve three core elements:*
>
> - *An* ***intention*** *that specifies an immediate goal and ... the behaviour necessary to achieve it.*
> - *The* ***actions*** *triggered by this intention - which may or may not conform to the action plan.*
> - *The* ***consequences*** *of these actions - which may or may not achieve the desired objective.*
>
> *"In the law,* ***a person who acts recklessly*** *is one who takes a deliberate and unjustifiable risk (that is one that is foreseeable, and where a bad outcome is likely, though not certain).*
>
> *"****Negligence, on the other hand****, involves bringing about a consequence that a 'reasonable and prudent' person would have foreseen and avoided.*
>
> *"Even wise and distinguished judges do not get it right all of the time.*
>
> *"****substitution test*** *... When faced with an accident or serious incident in which the unsafe acts of a particular person were implicated, we should perform the following mental test. Substitute the individual concerned for someone else coming from the same domain of activity and possessing comparable qualifications and experience. Then ask the following question: 'In the light of how events unfolded and were perceived by those involved in real time, is it likely that this new individual would have behaved any differently?' If the answer if 'probably not' then 'apportioning blame has no material role to play, other than to obscure systemic deficiencies and to blame one of the victims'. A useful addition to the substitution test is to ask of the individual's peers: 'Given the circumstances that prevailed at that time, could you be sure that you would not have committed the same or*

similar type of unsafe act? If the answer again is 'probably not', then blame is inappropriate.

*"The key questions relate to **intention**. If both the actions and the consequences were intended, then we are likely to be in the realm of criminal behaviour.*[23, extracts from section entitled *'Engineering a just culture'*."

Reason pointed out that human error can be viewed in two different ways: the person approach and the system approach. Each model gives rise to quite different philosophies of error management.

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention or moral weakness.

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects.[24]

He (James Reason) inspired and contributed to a tool known as *The Incident Decision Tree*. This was developed by the *National Patient Safety Agency* (NPSA) to help NHS managers determine a fair and consistent course of action toward staff involved in patient safety incidents.[25] It is based on a model called *The Culpability Tree*, an algorithm initially developed for dealing with staff involved in safety errors in the aviation industry.[23,26] The Incident Decision Tree has been superseded by ***A Just Culture Guide***, an *NHS England and Improvement* guide intended to support consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.[27]

The NHS **Just Culture Guide** highlights important principles that need to be considered before formal management action is directed at an individual staff member. It does this through a series of questions which probe whether or not the incident resulted from: intention to cause harm; the individual's health or state of mind; customary practice; how peers would have behaved in similar circumstances; mitigating circumstances if appropriate.

Q1: Deliberate harm test

1a Was there any intention to cause harm?

If the answer to 1a is Yes, the following recommendation applies:

Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

If the answer to 1a is No → Q2 (health test)

Q2: Health test

2a. Are there indications of substance abuse?

If the answer to 2a is Yes, the following recommendation applies:

Recommendation: Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier.

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

If the answer to 2b or 2c is Yes, the following recommendation applies:

Recommendation: Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier.

If the answers to 2a, 2b and 2c are all No → Q3 (foresight test)

Q3: Foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If the answer to any of questions 3a, 3b or 3c is No, the following recommendation applies:

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

If the answers to 3a, 3b and 3c are all Yes → Q4 (substitution test)

Q4: Substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If the answer to any of questions 4a, 4b or 4c is Yes, the following recommendation applies:

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

If the answers to 4a, 4b and 4c are all No → Q5 (mitigating circumstances)

Q5: Mitigating circumstances

5a. Were there any significant mitigating circumstances?

If the answer to 5a is Yes, the following recommendation applies:

Recommendation: Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

If the answer to 5a is No, the following recommendation applies:

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

The process ends following implementation of the relevant recommendation.

The NHS England website has a webpage, *A just culture guide*, which recognizes the need for managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.[28] It cites the report of the 2018 Williams *Gross Manslaughter Negligence* review [29], from which the following extract is taken:

> *'In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture*

also holds people appropriately to account where there is evidence of gross negligence or deliberate acts'.

Sidney Dekker, an academic with particular interests in human factors and safety, has described a just culture as being **a culture of trust, learning and accountability**. In his book **'Just Culture'** he states *that 'a just culture should enable your organization to learn from an incident, yet also hold people "accountable" for undesirable performance'.*[30]

Mersey Care NHS Foundation Trust have been proactive in this area, together with *Northumbria University*. Working with Sidney Dekker they are championing the concept of restorative just culture and offer training in the *Principles and Practice of Restorative Just Culture*.[31]

Dekker describes **Restorative Just Culture** as aiming *to repair trust and relationships damaged after an incident.*[32] *It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm*. He has created a checklist with further details of restorative just culture, including five key questions:

- *Who is hurt?*
- *What do they need?*
- *Whose obligation is it to meet the need?*
- *Ready to forgive?*
- *Achieved goals of restorative justice?*

The checklist describes the background to restorative just culture, distinguishing it from retributive just culture. It also contains guidance for use of the checklist. It highlights the hurts/harms which may be caused by an incident, and which create needs and obligations. It discusses forgiveness: *a relational process that involves truth-telling, repentance and the repair of trust*. It acknowledges that this takes time, and that trust is easy to break and hard to fix. It ends with a statement of the ***Goals of Restorative Just Culture***. I think that this statement is so important that it is worth quoting in full:[32]

- ***Moral engagement*** *can mean accepting appropriate responsibility for what happened, recognizing the seriousness of harms caused, and humanizing the people involved. Incidents can overwhelm an organization (e.g. a legal, reputational, financial, managerial issue). It is easy to forget that it is also a moral issue: What is the right thing to do?*
- ***Emotional healing*** *aims to deal with feelings such as grief, resentment, humiliation, guilt and shame. It is a basis for repairing trust and relationships.*
- ***Reintegrating*** *the practitioner expresses the trust and confidence that the incident is about more than just the individual. Expensive lessons can disappear from the organization if the practitioner is not helped back into the job, and letting them go tends to obstruct the three other goals. If you fire someone, what have you fixed?*
- *Restorative justice is better geared toward* ***addressing the causes*** *of harm because it goes beyond the individual practitioner and invites a range of stories and voices. Forward-looking accountability is about avoiding blame, and instead fixing things.*

The concepts of **restorative justice** and **restorative practice** are closely linked to Restorative Just Culture.[33]

Restorative justice brings those harmed by crime or conflict and those responsible for the harm into communication, enabling everyone affected by a particular

incident to play a part in repairing the harm and finding a positive way forward. This is part of a wider field called restorative practice.

Restorative practice can be used anywhere to prevent conflict, build relationships and repair harm by enabling people to communicate effectively and positively. Restorative practice is increasingly being used in schools, children's services, workplaces, hospitals, communities and the criminal justice system.

Restorative practice can involve both a proactive approach to preventing harm and conflict and activities that repair harm where conflicts have already arisen.

The Restorative Justice Council has identified six **principles of restorative practice**.[34]

1. *Restoration – the primary aim of restorative practice is to address participants needs and not cause further harm. The focus of any process must be on promoting restorative practice that is helpful, explores relationships and builds resilience.*
2. *Voluntarism – participation in restorative practice is voluntary and based on open, informed and ongoing choice and consent. Everyone has the right to withdraw at any point.*
3. *Impartiality – restorative practitioners must remain impartial and ensure their restorative practice is respectful, non-discriminatory and unbiased towards all participants. Practitioners must be able to recognise potential conflicts of interest which could affect their impartiality.*
4. *Safety – processes and practice aim to ensure the safety of all participants and create a safe space for the expression of feelings and views which must result in no further harm being caused.*
5. *Accessibility – restorative practice must be respectful and inclusive of any diversity needs such as mental health conditions, disability, cultural, religious, race, gender or sexual identity.*
6. *Empowerment – restorative practice must support individuals to feel more confident in making their own informed choices to find solutions and ways forward which best meet their needs.*

The gov.uk website contains a collection of items on restorative justice. [35]

Restorative justice brings together people harmed by crime or conflict with those responsible for the harm, to find a positive way forward.

Restorative justice gives victims the chance to tell offenders the real impact of their crime, get answers to their questions and get an apology.

Restorative justice holds offenders to account for what they have done. It helps them understand the real impact, take responsibility, and make amends.

Holding offenders to account is a key component of both restorative justice and just culture. They are closely linked.

Groundbreaking work on restorative justice is being carried out in New Zealand, at the Victoria University of Wellington *Te Ngāpara Centre for Restorative Practice*. This work is led by the *Diana Unwin Chair in Restorative Justice*.[36]

17 Clue: *Do national staff surveys provide assurance that NHS staff are confident they will be safe if they speak up?* (2)

Answer: **NO**

The NHS England national staff survey has been conducted annually since 2003. It is one of the largest workforce surveys in the world. 280 NHS organisations took part in 2021, including all 217 trusts in England. 648,594 staff responded to the invitation to take part in 2021, a response rate of 48%.[31] This sample size endows the national staff survey with high statistical power.

The 2021 survey questions were divided into nine summary indicators:[37]

- *We are compassionate and inclusive*
- *We are recognised and rewarded*
- ***We each have a voice that counts***
- *We are safe and healthy*
- *We are always learning*
- *We work flexibly*
- *We are a team*
- *Staff Engagement*
- *Morale*

The first seven of these summary indicators were introduced in 2021 to provide an overview of staff experience in relation to the seven elements of the People Promise.[38]

The '***We each have a voice that counts***' indicator is divided into two categories:

- *Autonomy and control*
- ***Raising concerns***

The *Raising concerns* category is based on survey questions q17a-b and q21e-f. This category is sub-divided into two sub-categories:

- Concerns about clinical safety in particular (q17a-b)
  q17a: *"I would feel secure raising concerns about unsafe clinical practice"*
  q17b: *"I am confident that my organisation would address my concern"*
- Speaking up about concerns in general (q21e-f)
  q21e: *"I feel safe to speak up about anything that concerns me in this organisation"*
  q21f: *"If I spoke up about something that concerned me I am confident my organisation would address my concern"*

The survey results for these questions from the 217 NHS England trusts were:

q17a: 74.9% said they would feel secure raising concerns about unsafe clinical practice
q17b: 59.4% were confident that their organisation would address their concern
q21e: 62.0% said they feel safe to speak up about anything that concerns them in their organisation
q21f: 49.8% were confident that their organisation would address their concern

Overall, these results do not provide assurance that NHS staff are confident they will be safe if they speak up. Preliminary analysis of the results for one trust shows much poorer confidence amongst clinical staff than non-clinical/corporate staff that they will be safe if they speak up.

23 Clue: *A temporary relief, which must be claimed within 7 days after dismissal, preserving employment pending employment tribunal decision on claim for unfair dismissal* (7)

Answer: **INTERIM**

Employees who have been dismissed after raising concerns may apply for interim relief pending a full employment tribunal hearing if certain conditions apply.[39] Applications for interim relief need to be made to the employment tribunal within seven days after the effective date of termination.

> *Interim Relief is an order by the Employment Tribunal that preserves your employment (at least so far as pay is concerned) until after the tribunal has decided your claim for unfair dismissal. It is only available to employees who have just been dismissed and can show that they are "likely" to win their whistleblowing claim.*[40]

If the application for interim relief is successful the employment tribunal may ask the employer to reinstate or re-engage the employee pending the outcome of the full hearing. If, then, the employer is unwilling to reinstate or re-engage the employee the tribunal shall order continuation of the employee's contract of employment until the full hearing.[39]

Further information about interim relief is available from a number of sources, including the charity *Protect*.[40]

26 Clue: *Type of leadership, with moral compass directional provenance, advocating attending, understanding, empathising and helping* (13)

Answer: **COMPASSIONATE**

This clue includes a cryptic reference to the surname of Michael West, Professor of Work and Organisational Psychology at the University of Lancaster and Senior Fellow at the Kings Fund.[41] His work over a number of years has included a focus on **compassionate leadership**.

A recent Kings Fund article asks *'What is compassionate leadership?'*[42] It starts with a **definition of compassion** from Paul Gilbert:

> *'a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it'*.[43]

It goes on to outline what **compassionate leadership** involves, and why it is important:

> *Compassionate leadership involves a focus on relationships through careful listening to, understanding, empathising with and supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work. There is clear evidence that compassionate leadership results in more engaged and motivated staff with high levels of wellbeing, which in turn results in high-quality care.*[44]

Citing earlier work by Atkins and Parker [45], the article identifies four behaviours of compassionate leadership: *attending*, *understanding*, *empathising* and *helping*.[42]

Attending

> *This means being present with and focusing on others – 'listening with fascination'*.[46]. *Listening is probably the most important leadership skill and compassionate leaders take time to listen to the challenges, obstacles, frustrations and harms colleagues experience as well as listening to accounts of their successes and joys*.[44]

Understanding

This involves taking time to properly explore and understand the situations people are struggling with. It implies valuing and exploring conflicting perspectives rather than leaders simply imposing their own understanding.[47]

Empathising

This involves mirroring and feeling colleagues' distress, frustration, joy, etc, without being overwhelmed by the emotion and becoming unable to help.[48]

Helping

This involves taking thoughtful and intelligent action to support individuals and teams. Removing obstacles that get in the way of people doing their work (e.g. chronic excessive workloads, conflicts between departments) and providing the resources people and services need (e.g. staff, equipment, training) are the most important tasks for leaders.[49]

Research shows that compassionate leadership has wide-ranging benefits for both staff and organisations.[42] The following referenced extracts from the article summarise these benefits:

People who work in supportive teams with clear goals and good team leadership, have dramatically lower levels of stress

Compassionate leadership increases staff engagement and satisfaction, resulting in better outcomes for organisations including improved financial performance

In NHS trusts where staff report the absence of such leadership, staff also report higher levels of work overload and less influence over decision-making

Staff who are treated with compassion are better able to direct their support and care giving to others

This results in higher-quality care and higher levels of patient satisfaction

Where staff generally report the absence of such leadership there are lower levels of patient satisfaction, there is poorer-quality care and (in the acute sector) higher patient mortality

Perhaps the best known UK example of such poor quality care and higher patient mortality is the *Mid Staffs scandal*.[50] The report of the resultant *Public Inquiry* raised awareness of the need for compassionate care in the consciousness of healthcare leaders.[51] Conscientious healthcare professionals around the world may have wondered why compassion was not already central to the thinking of all concerned.

West notes that ***compassionate leaders constantly strive to understand and meet the core needs of the people they work with***.[44]

This reference to core needs of healthcare staff parallels the fundamental place of physiological needs in Maslow's classic *hierarchy of needs*.[52] Maslow pointed out that basic physiological and safety needs must be met if higher level psychological and self-fulfilment needs can be met. Applying this to healthcare settings, healthcare leaders must ensure that core needs of staff are met if they are to deliver high quality care to patients.

Bailey and West cite eight features of the workplace which determine how well the core needs of health and care staff at work are met.[42] They are grouped under three headings: *Autonomy*, *Belonging* and *Contribution*:

Autonomy

The need to have autonomy over one's work life, and to be able to act consistently with one's values

1. Authority, empowerment and influence
2. Justice and fairness
3. Work conditions and working schedules

Belonging

The need to be connected to, cared for by, and caring of colleagues, and to feel valued, respected and supported

4. Teamworking
5. Culture and leadership

Contribution

The need to experience effectiveness in work and deliver valued outcomes

6. Workload
7. Management and supervision
8. Education, learning and development

Compassionate leaders ensure that all three of these core human needs are met at work. They provide an environment in which staff have appropriate autonomy and control over work activities; a sense of belonging; and a sense of effectiveness of contribution in the workplace.

> *Leadership means not just individual leaders in organisations but the leadership in the whole of the NHS. It includes the bodies and ministers that oversee the NHS – NHS Improvement, CQC, Department of Health, NHS England. If the way these agencies interact with the system is (or is perceived as) directive, controlling, punitive, threatening or uncaring, then compassion dries up and an environment is created in which bullying becomes dominant.*[53]

27 Clue: *Abbreviation for 'independent review into creating an open and honest reporting culture in the NHS' published in 2015* (4)

Answer: **FTSU**

The then Secretary of State for Health commissioned the *Freedom To Speak Up* Review in the summer of 2014. This was in response to a number of serious incidents in the NHS. Some of these were scandals which could have been prevented if staff had spoken up about poor patient care, including at the former *Mid Staffordshire NHS Foundation Trust*. Other incidents involved a number of cases in which staff had suffered serious retaliation from their employers after raising concerns with hospital managers about unsafe care or wrongdoing such as fraud.

The *Freedom To Speak Up* Review was described as an *independent review into creating an open and honest reporting culture in the NHS*. It was led by Sir Robert Francis QC. The report of the review was published on 11 February 2015.[5]

The first paragraph of the Executive Summary of the report [54] reads:

> *This Review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by NHS staff and the treatment of some of those who have spoken up. In recent years there have been exposures of substandard, and sometimes unsafe, patient care and treatment. Common to many of them has been a lack of awareness by an organisation's leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did.* ***The 2013 NHS staff survey showed that only 72% of respondents were confident that it is safe to raise a concern.*** *There are disturbing reports of what happens to those who do raise concerns. Yet failure to speak up can cost lives.*

The abbreviation '*FTSU*' is often used for *'Freedom To Speak Up'*.

The following extracts are taken from a press statement [55] in which Francis wrote:

> *When I began my work, I had an open mind about what I might find. What I heard during the course of the review, from staff, employers, regulators, unions and others, leaves me in no doubt that there is a serious problem in the NHS.*
>
> *If, as this Review has shown, safety issues known to staff are not always being addressed, then patient safety will be at risk. It is just as important to protect the integrity of the service. If it loses money because of dishonestly or incompetence, or misleading information is given out, our trust in the NHS is diminished. If, as the evidence suggests can happen, staff do not feel free to speak up about such matters our trust in the NHS will be diminished.*
>
> *I received over 600 contributions from people with experiences and views they wanted to share. Over 19,500 completed an independent online survey. I met over 300 personal contributors and representatives of organisations in individual, group meetings and seminars.*
>
> *Unfortunately there are some places where too many staff are afraid – afraid that if they raise difficult or contentious issues they will not be listened to, nothing will happen, or, worse, that they will be bullied or have the finger of blame pointed at them. Too many of them have seen colleagues suffer for trying to raise honest concerns, and inaction when action is desperately needed. Too often honestly expressed anxieties are met with hostility, and a breakdown of working relationships. Worse still, sometimes people suffer life changing events – they lose their jobs, their careers, even their health.*
>
> *We need to establish everywhere a culture in which:*
> - *all staff feel safe to raise their concerns*
> - *speaking up about what worries them is a normal part of everyone's routine*
> - *if they do speak up they are free from the fear that they will be bullied and badly treated*
> - *leaders at all levels demonstrate through their own behaviour that they welcome and encourage the raising of concerns*
>
> *Everyone knows that culture change is not easy. What I have aimed for in my report is to set out some steps I believe will help bring this about – principles for all to follow and practical actions to put safety at the centre of NHS culture, to make raising concerns the normal thing to do, ensuring leaders are visible and bullying is not tolerated.*

The 2021 NHS staff survey showed that only 62% of respondents were confident that it is safe to raise a concern.[18] Less than half (49.8%) were confident that their organisation would address their concern.[56]

28 Clue: *American activist credited with coining the term whistleblower* (5)

Answer: **NADER**

The American political activist Ralph Nader is sometimes credited with coining the term 'whistleblower', in a *Conference on Professional Responsibility* held at the Mayflower Hotel in Washington DC in 1971.

The following extracts are taken from an interview with Nader published in *Whistleblower Network News* in 2021:[57]

> *Nader believed employees who report crime and corruption were only doing their job: "the basic status of a citizen in a democracy," Nader said at the event, includes fulfilling their "professional individual and responsibility."*
>
> *During his keynote speech at the Mayflower Hotel on Jan. 30, 1971, Nader presciently observed that employees' allegiance to society should outweigh that to a company, citizens' privacy was being eroded by over-reaching organizations, and whistleblower protection laws needed to be passed – including to shield public whistleblowers.*
>
> *A half-century after what he calls "decisively" the first whistleblower conference ever held in the U.S., Nader says he's both gratified and surprised by the progress that's been made since.*
>
> *"It was one of the more pretentious and effective conferences ever held in the pursuit of democracy. That was the conference that started the whole whistleblowing movement."*
>
> *"When I started out on the whistleblowing issue, whistleblowers were considered, as you know from history, snitches and disgruntled employees. I wanted to redefine the public understanding of the crucial role of people who take their conscience to work. People who take their conscience to work and practice it are ipso facto professionals."*
>
> *This effort to recast witnesses in the workplace as heroes rather than traitors is succeeding, Nader said. "The important thing is how people react when they hear the word 'whistleblower.'*

In a book about the conference which Nader co-edited, whistleblowing is defined as:

> *"the act of a man or woman who, believing that the public interest overrides the interest of the organisation he serves, publicly 'blows the whistle' if the organisation is involved in corrupt, illegal, fraudulent or harmful activity"*.[58]

29 Clue: *A difficult situation in which staff may find themselves when considering if and how to raise concerns* (7,7)

Answer: **ETHICALDILEMMA**

It ought to be straightforward for staff to be able to raise concerns. However, they may find themselves in an ethical dilemma. This may involve conflicts of loyalty.

If a member of staff is aware of poor practice within the organisation in which they work they may be inhibited from reporting it, for various reasons. These reasons might include reluctance to be critical of a colleague, or colleagues if this could be construed as 'telling tales'. There might be a sense that pointing out that all is not well would not be the action of a good team player - particularly if the prevailing organisational culture is one of exaggerated hype. There might be a fear that the concerns would not be well-received if they contradict messages from others that all is well - with trepidation that speaking up could lead to retaliation against anyone who has had the temerity to suggest otherwise.

However, despite any such inhibitions, the *NHS Constitution* tells staff that they have rights and responsibilities to *raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest reasonable opportunity*.[59]

Furthermore, healthcare professionals are required by their professional codes of conduct to raise, and if necessary escalate, such concerns.

According to the NHS Constitution the NHS pledges to *encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised.*[59] Sadly there is evidence that this pledge is not always fulfilled - innumerable staff have suffered sometimes life-changing reprisals from their employers after raising valid concerns.[5]

All things considered, staff may find themselves in a very difficult situation when considering whether or not and how to raise concerns. They may be placed in a serious ethical dilemma, wondering how to balance conflicting loyalties.

31 Clue: *Problems arise when organisations place this above the truth or treating those raising concerns well and fairly* (10)

Answer: **REPUTATION**

'Learning not blaming' was published by the *Department of Health* in July 2015. It is the government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation.[60]

The Ministerial Foreword from the then Secretary of State for Health refers to *shocking evidence amassed by Sir Robert Francis QC in his Freedom to Speak Up review* (which) *details the price paid by far too many NHS staff who spoke up with concerns about the quality of care. Those who should have listened to those concerns - and acted on them - responded instead in many cases with evasiveness and hostility.*

The Introduction to *Learning not blaming* contains the following extract:

> *Following the publication of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust, there was a widespread recognition that the NHS needed to radically improve the way it responded to concerns from staff and the public.* ***A defensive culture more concerned with reputation than with either the truth,***

> ***or with treating those raising concerns well and fairly, had grown up over several years.*** *A number of brave individuals and progressive organisations (including many front line providers) stood against this culture, and give us the confidence that a different and a better way is possible for all and not just some. The imperative now is to make sure that honesty and openness is not the heroic exception, but the normal expectation throughout the NHS.*

Organisations who place reputation above the truth, or treating those raising concerns well and fairly, must understand that in doing so they are failing in their fundamental duties towards patients, and to those who raise concerns.

33 Clue: *Insightful adjective to describe a healthcare professional who raises patient safety concerns* (5)

Answer: **LOYAL**

The online Cambridge English Dictionary defines the meaning of 'loyal' as:

> *"firm and not changing in your friendship with or support for a person or an organization, or in your belief in your principles."*[61]

Healthcare professionals have multiple loyalties. They have loyalties to patients; to their families and friends; to their employers; to their work colleagues; and to their profession. They also owe loyalty to their own career, for which most have worked hard to gain relevant qualifications, knowledge, skills and experience.

Different people may rank these and other loyalties in different orders, but I suspect few would argue against placing loyalty to patients first, when considering workplace loyalties in healthcare settings. There may be debate about which patients have priority when resources are limited but that is a secondary question in this context. Few would openly defend healthcare organizations which admit to placing their reputation above patient safety.

In the case of healthcare professionals working for the NHS, their organizational loyalty is split between loyalty to the part of the system which is their actual employer, and loyalty to the wider system - or indeed systems. The NHS is a *national* health service, a highly complex system of micro-, macro- and meta-systems.

NHS England has a constitution, the ***NHS Constitution for England***.[59] This puts on record the *principles that guide the NHS* and *NHS values*. It identifies rights and responsibilities of patients and staff. It makes specific pledges to patients and staff. The following extracts are copied from the NHS Constitution, with those related to raising concerns highlighted:

> ***Staff: your rights and NHS pledges to you***
>
> *All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they* ***need to be trusted, actively listened to and provided with meaningful feedback.*** *They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress.*
>
> ***Your rights***
>
> *Staff have extensive legal rights, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS*

Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- *have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives*
- *have a fair pay and contract framework*
- *can be involved and represented in the workplace*
- *have healthy and safe working conditions and an environment free from harassment, bullying or violence*
- *are treated fairly, equally and free from discrimination*
- *can in certain circumstances take a complaint about their employer to an Employment Tribunal*
- ***can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.***

NHS pledges

In addition to these legal rights, there are a number of pledges, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS pledges to:

- ***provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability***
- *provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities*
- *provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential*
- *provide support and opportunities for staff to maintain their health, wellbeing and safety*
- *engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements.* ***All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge)***
- *to have a process for staff to raise an internal grievance (pledge)*
- ***encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised*** *and acting consistently with the Employment Rights Act 1996*

Staff: your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes expectations that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim to:

- *provide all patients with safe care, and to do all you can to protect patients from avoidable harm*
- ***follow all guidance, standards and codes relevant to your role,*** *subject to any more specific requirements of your employers*
- *maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole*
- *find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs)*
- *take up training and development opportunities provided over and above those legally required of your post*
- *play your part in sustainably improving services by working in partnership with patients, the public and communities*
- ***raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest reasonable opportunity***
- *involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment*
- *be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation*
- ***contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged*** *and colleagues are supported where errors are made*
- *view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care*
- *take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing*

- *contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care*
- *inform patients about the use of their confidential information and to record their objections, consent or dissent*
- *provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.*

It is clear from the above that staff who are aware of poor practice, particularly when it affects patient safety, are required to raise concerns through appropriate channels (typically through their line manager, though there are other legitimate routes for raising concerns). Any suggestions that anybody raising such concerns is being disloyal to the organisation, or to colleagues, are entirely wrong.

It is not in the interests of healthcare providers for concerns about patient safety in particular to be suppressed. Organisations who suppress concerns about patient safety and retaliate against staff who raise them are themselves being disloyal. In so doing they are failing to discharge their responsibilities to patients, to staff and to the NHS as a whole.

Unfortunately, in the topsy-turvy world of whistleblowing, organisational response to staff who raise concerns is sometimes to brand them as disloyal. The following description of organisational response to whistleblowers is from psychiatrist Jean Lennane:[62]

The aims of the organisation's response are:

1. *to isolate the whistleblower by removal from the accepted "in-group" (one of us) to "out-group" status, by representing the whistleblower as:*
    - *incompetent*
    - *disloyal*
    - *a ratbag*
    - *mentally unbalanced/ill*
2. *to frighten others who might otherwise support the whistleblower*
3. *to avoid examining or remedying the issue the whistleblower is complaining about.*

Not all organisations behave in this way, thank goodness. But sadly there is abundant evidence that organisational response like this is widespread within the NHS.[5,54,55,60] It is organisations and their representatives who behave in this way who are disloyal, not the whistleblowers. Just culture requires that those who behave in this way be held to account.[22-36]

Early in Lennane's paper she notes that '*The whistleblower acts on principle. ... The whistleblower is almost always following the principles that society and the organisation claim are their norm.*' (Lennane's point here is that organisational culture and practice, for example freedom to speak up, may not be and usually are not what organisations claim to be the case.) She ends her classic paper with the statement: '*Whistleblowers represent an important and valuable resource in helping to keep standards the way we would like them to be.*'[62]

Author and businesswoman Margaret Heffernan has written: '***The overwhelming majority of whistleblowers are deeply loyal, committed employees who have high expectations of their organisations***.'[63] She has said '*I've interviewed hundreds of whistleblowers in all walks of life and I have never encountered an organisation as vicious in its treatment of them as the NHS*'.[64]

34 Clue: *A troubling matter which needs to be raised with someone who may be able to take effective action to resolve it* (6)

Answer: **CONCERN**

Comment

35 Clue: *Retaliatory actions* (9)

Answer: **REPRISALS**

Comment

36 Clue: *NHS responsibility to support staff whose performance is sound but who have suffered as a result of speaking up* (5,10)

Answer: **MORALOBLIGATION**

Comment

Down

1 Clue: *Analogy sometimes used in training material for a concern raised with NHS managers, guiding how they should respond* (4)

Answer: **GIFT**

Comment

2 Clue: *What can be avoided, or their impact reduced, if organisations listen and respond properly to staff who raise concerns?* (8)

Answer: **SCANDALS**

Comment

4 Clue: *Term for raising concerns preferred by National Guardian Office* (8,2)

Answer: **SPEAKINGUP**

Comment

6 Clue: *Educational activity, as opposed to blaming, embodied in title of 2015 UK government response to three reports on patient safety* (8)

Answer: **LEARNING**

Comment

7 Clue: *A theoretical model devised by James Reason which illustrates how a layered approach supports safety, but fails if systemic weaknesses align* (5,6)

Answer: **SWISSCHEESE**

Comment

8 Clue: *Belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes* (13,6)

Answer: **PSYCHOLOGICALSAFETY**

Comment

12 Clue: *Flawed perception of a conscientious worker who speaks up* (12)

Answer: **TROUBLEMAKER**

Comment

16 Clue: *Author of Just Culture: Restoring trust and accountability in your organization* (6)

Answer: **DEKKER**

Comment

18 Clue: *Colloquial term for people who report concerns in the public interest, e.g. patient safety issues* (14)

Answer: **WHISTLEBLOWERS**

Comment

19 Clue: *Derogatory whistleblower synonym, grossly inappropriate and misleading when applied to healthcare professionals and others who raise valid concerns in the public interest* (5)

Answer: **SNEAK**

Comment

20 Clue: *Entirely wrong, but sadly not uncommon, type of action taken by some employers against employees who raise valid concerns* (12)

Answer: **DISCIPLINARY**

Comment

21 Clue: *Widely-acknowledged description of UK legislation which in theory, if not in practice, is supposed to protect workers who make protected disclosures* (4)

Answer: **WEAK**

Comment

22 Clue: *Inappropriate term sometimes wrongly used for whistleblower - rhymes with witch* (6)

Answer: **SNITCH**

Comment

24 Clue: *How should people who harm whistleblowers be held?* (2,7)

Answer: **TOACCOUNT**

Comment

25 Clue: *An inequality typically faced by individuals pursuing employment tribunal claims of detriment / unfair dismissal after raising concerns in the public interest* (2,4)

Answer: **OFARMS**

Comment

30 Clue: *Principles espoused by organisations to describe fundamental beliefs and expected employee behaviour* (6)

Answer: **VALUES**

Comment

32 Clue: *Public Interest Disclosure Act (abbreviation)* (4)

Answer: **PIDA**

Comment

References

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