

**Public Concern at Work**

Suite 301

16 Baldwins Gardens

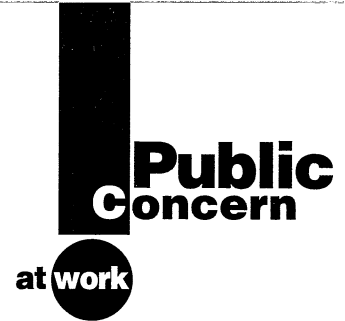
London EC1N 7RJ

**Telephone** 020 7404 6609

**Fax** 020 7404 6576

whistle@pcaw.co.uk

www.whistleblowing.org.uk



**Mr Robert Francis QC**  
Mid Staffordshire Inquiry  
7th Floor  
New Kings Beam House  
22 Upper Ground  
London  
SE1 9BW

14 December 2009

Dear Mr Francis QC,

**Submission on behalf of Public Concern at Work to the independent inquiry into the care provided by the Mid Staffordshire NHS Foundation Trust**

We wish to make a short submission on some of the important lessons that could be learned from the emerging story of what happened at Mid Staffordshire NHS Foundation Trust (Mid Staffs). Our comments are limited to the value of getting whistleblowing right, with some specific comments on what we know having reviewed the whistleblowing policy in place at Mid Staffs during the relevant period for this inquiry. We conclude by outlining best practice for whistleblowing arrangements which illustrates what steps the Trust, or indeed any organisation, should take to ensure their whistleblowing arrangements are fit for purpose.

Our comments build on and provide practical guidance on how to meet some of the concerns and recommendations given by Dr Colin-Thomé in his report. In particular this submission addresses his third recommendation<sup>1</sup> which states:

“All health professionals who have contact with patients and the public must report concerns quickly. PCTs and providers should have systems in place for healthcare professionals to report concerns easily and quickly and should be held to account for the setting up of such systems.”

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<sup>1</sup> Summary of recommendations: involving patients and the public. Page 15 Report of Dr Colin- Thome

## About us

Public Concern at Work (PCaW) is the leading and independent authority on whistleblowing. PCaW was instrumental in setting up the legislative framework for whistleblowing in the UK under the Public Interest Disclosure Act 1998 (PIDA). We operate a free, expert helpline for workers who wish to raise a public concern (such as medical malpractice, fraud or other misconduct) and provide bespoke training and consultancy across the public, private and voluntary sectors. Recently we have worked with numerous trade unions, professional bodies and regulators including the Financial Services Authority, Ofsted and the Care Quality Commission. In July last year, we produced a Code of Practice on Whistleblowing Arrangements in partnership with the British Standards Institution on how to get whistleblowing right (a copy of which can be downloaded at [www.pcaw.co.uk/bsi](http://www.pcaw.co.uk/bsi)).

In February 2008, we won the Department of Health tender to provide advice for staff and NHS organisations in England, (including developing a whistleblowing policy pack for NHS entities) for three years. We have had contact with thousands of health professionals during the last 16 years. We receive the largest proportion of our calls from the health and care sectors. In the six month period 1 April to 30 September 2009, 21.4% of calls were from the health and social care sectors. (57% declared to be from an NHS related organisation, the remainder deemed to be so, or more generally from the care sector). Of these calls 75.4% were classed a public concern and 24.6% as private calls. By public we mean those involving a whistleblowing concern i.e. raising a matter - such as a patient safety risk or financial wrongdoing - which affects others or the organisation itself. Private calls are those calls that involve questions about the caller's private employment rights such as bullying and harassment, redundancy and the like. This year there was an increase of 5% from the number of public calls received in the same period last year.

It is vital to staff, patients and the public that organisations recognise the role they must play in making whistleblowing work. Dr Colin-Thomé's report highlighted that "the hospital trust itself was perceived as having a 'closed' culture, and were not open with sharing of information"<sup>2</sup>. When an organisation chooses (or it is perceived) not to listen to its staff, staff may not feel safe raising their concern inside or even outside their organisation. The risk is that they may choose the most dangerous option for patient safety - silence. Clearly it is in everyone's interest that we work towards a culture in which staff can and do challenge poor quality care without fear of reprisal.

The language of a policy can be indicative of whether or not a Trust is fostering such a culture. Our analysis of the messages, tone and nuances of the policy in place at Mid-Staffs in the relevant period reveals clear warning signs about the culture within Mid Staffs at the relevant time.

We wish to stress that a good policy is just the starting point and we will later detail the key elements of best practice in establishing robust whistleblowing arrangements.

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<sup>2</sup> Page 12

### **Mid-Staffordshire NHS Foundation Trust**

We have been asked by Bill Cash MP to review Mid Staffs 2007 whistleblowing policy. We do not have any information on how well the policy was communicated to staff or whether it was ever reviewed; therefore our comments are restricted to the language of the policy itself and what this tells us about: a) how safe a member of staff would feel in using the policy; and b) how the Trust communicated with staff.

We identified the following weaknesses in the policy:

- Overly legalistic - the policy went straight into legal terms and was not written in plain English, reducing its accessibility and offering very little reassurance to staff members.
- The explanation of the law was wrong - e.g. section 4.1 says all staff have a responsibility to “raise concerns in good faith with a true belief that a malpractice has occurred”. It is more helpful to say that staff should raise a concern when they have a “genuine suspicion” - this encourages staff to speak up at the earliest opportunity, providing an opportune to avert harm. Staff should know that they do not need to have proof or have to be sure before they approach their organisation with critical information. Additionally this wording reflects the approach of the law in relation to internal disclosures.
- The duty of fidelity was put above raising a concern “as members of staff have a duty of loyalty to the Trust as their employer it is important that trust between employer and employee is not compromised”. This is at odds with the codes of conduct of professional bodies. There is a real danger that this would deter staff from raising their concern.
- The designated officer was the Deputy Chief Exec - from our experience it is better to have 3 stages: 1. line manager; 2. designated senior manager(s); and 3. Chief Executive or Non-Executive Director. Alternatively or additionally this third stage could be a contact on the Board of Governors for foundation trusts.
- The Department of Health was not listed as an external option.
- The list of regulators did not include the most relevant regulator at the time - the Healthcare Commission.
- Assurances to staff were right at the end of the policy. It is sensible to provide such assurances at the beginning. Good assurances in a policy should include, for example, a statement to staff that they will not be at risk of losing their job if they raise a genuine concern using the policy.
- The policy attempted to combine messages to managers as well as to staff - we find it is better to separate out management guidance from the whistleblowing policy.
- The Secretary of State for Health, NHS Fraud hotline and Counter-Fraud officer were offered as sources of advice, when in reality these are people to whom disclosures could be made.

It should be noted that in July 2009 we were contacted by Mid Staffordshire Foundation Trust to review a new whistleblowing policy. We have provided our detailed comments on this to them and we understand that this is a work in progress. Whilst it is a great improvement on its predecessor there is still work to be done.

### **Guidance on whistleblowing arrangements**

As mentioned above we worked in partnership with the British Standards Institution to produce a comprehensive Code of Practice showing organisations how to get whistleblowing arrangements right. The document explains the key principles in whistleblowing and highlights good practice on leadership, the policy, communication, implementation, audit and review. The Code of Practice incorporates and builds on the guidance from the Committee on Standards in Public Life (CSPL) and 16 years of our experience in public interest whistleblowing. For ease, outlined below are the key principles established by CSPL upon which the Code of Practice is built.

#### *Best practice*

The approach and recommendations of CSPL have been adopted by the Combined Code and regulatory bodies as relevant to organisations in all sectors. Emphasising the important role whistleblowing can play in deterring and detecting malpractice and in building public trust, the Committee has explained: "The essence of a whistleblowing system is that staff should be able to by-pass the direct management line, because that may well be the area about which their concerns arise, and that they should be able to go outside the organisation if they feel the overall management is engaged in an improper course."

In making this work, the Committee has said that "leadership, in this area more than in any other, is paramount" and that the promotion of the whistleblowing arrangements is critically important. The Committee has long distinguished a 'real' internal whistleblower from an anonymous leaker to the press and has recently stressed that the Public Interest Disclosure Act should be seen as a 'backstop' for when things go wrong and not as a substitute for an open culture.

#### *Good policy*

Drawing in part on the practical experience of Public Concern at Work, CSPL recommended that a good whistleblowing policy should make the following points clear:

1. The organisation takes malpractice seriously, giving examples of the type of concerns to be raised, so distinguishing a whistleblowing concern from a grievance.
2. Staff have the option to raise concerns outside of line management.
3. Staff are enabled to access confidential advice from an independent body.
4. The organisation will, when requested, respect the confidentiality of a member of staff raising a concern.
5. When and how concerns may properly be raised outside the organisation (e.g. with a regulator).
6. It is a disciplinary matter both to victimise a bona fide whistleblower and for someone to maliciously make a false allegation.

#### *Good practice*

The CSPL "emphatically endorsed" additional elements of good practice drawn from Public Concern at Work's evidence that organisations should:

- (i) ensure that staff are aware of and trust the whistleblowing avenues;

- (ii) make provision for realistic advice about what the whistleblowing process means for openness, confidentiality and anonymity;
- (iii) continually review how the procedures work in practice; and
- (iv) regularly communicate to staff about the avenues open to them.

In its White Paper on Standards, the Government responded that "it agrees on the importance of ensuring that staff are aware of and trust the whistleblowing process, and on the need for the boards of public bodies to demonstrate leadership on this issue. It also agrees on the need for regular communication to staff about the avenues open to them to raise issues of concern."

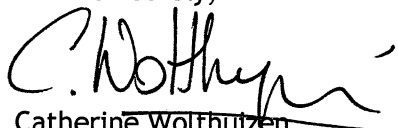
*Good audit*

The Institute of Chartered Accountants in England & Wales produced guidance on the whistleblowing obligations that companies have under the Combined Code on Corporate Governance and can apply equally to public sector organisations. They recommended that organisations include the following questions when they review the efficacy of their arrangements:

- Are there issues or incidents which have otherwise come to the board's attention which they would have expected to have been raised earlier under the company's whistleblowing procedures?
- Are there adequate procedures to track the actions taken in relation to concerns made and to ensure appropriate follow-up action has been taken to investigate and, if necessary, resolve problems indicated by whistleblowing?
- Have confidentiality issues been handled effectively?
- Is there evidence of timely and constructive feedback?
- Have any events come to the committee's or the board's attention that might indicate that a staff member has not been fairly treated as a result of their raising concerns?
- Is a review of staff awareness of the procedures needed?

We hope our comments outlining past problems and best practice are helpful to the inquiry and provide assistance in providing practical guidance on how the recommendations in Dr Colin-Thomé's report could be met. We should further mention that we are working with the Department of Health to produce guidance on whistleblowing arrangements for NHS organisations which we hope will be available in early 2010. We would be happy to provide further detail on any of the material outlined in this response and to answer any other questions regarding whistleblowing best practice.

Yours sincerely,

  
Catherine Wolthuisen  
Director