Middlesex University London

The Independent Review into creating an open and honest reporting culture in the NHS

Thematic Analysis of the Electronic Submissions to 'Freedom to Speak-Up'

Final Report

Alessio D'Angelo, Dora Papadopoulou,

Patricia Jarrett, David Lewis

October 2014

NOTE

This report for the Freedom to Speak Up Review have been written by researchers at Middlesex University. Any queries on their content should be directed to them.

The interpretations and conclusions in this report are those of the researchers and do not necessarily reflect the views of Sir Robert Francis, chair of the Review.

This report is based on an analysis of 402 of the 612 contributions to the Review from individuals, which were received before the official deadline for contributions. All 612 contributions were analysed by the Review team.

CONTENTS

1. Introduction

This report presents the findings of thematic analysis of the submissions to 'Freedom to Speak Up', the independent review into creating an open and honest reporting culture in the NHS.

The exercise focused on the classification, coding and analysis of the entries submitted through the 'Share your experience' online form, part of the Freedom to Speak Up website.

The study was commissioned by the Review team and conducted by researchers at Middlesex University. The research team involved Dr. Alessio D'Angelo, Dora Papadopoulou, Patricia Jarrett and Prof. David Lewis. For further information please contact: a.dangelo@mdx.ac.uk

1.1. Data and methods

This report is based on the classification and analysis of all the submissions received by the Research Team; these included 447 redacted online forms submitted before mid-September.

Table 1.1.1. – Number of analysed submissions

Redacted versions	Entered into database
Individuals	402
Unsuitable format	42
Duplicates	7
Total	**451**

The electronic submissions were converted from .doc/.docx file format into .txt and edited as appropriate to facilitate thematic analysis. In total, 402 individual submissions were imported into an electronic data-base with Qualitative Data Analysis Software 'NVivo' (version 10). Further 49 records were not included in the analysis because they were either in an unsuitable format or were duplicates of other entries.

The Middlesex University Research Team, being aware of data sensitivity, has handled submissions with strict confidentiality. The records were securely stored on Middlesex University protected network and have been accessed only by appointed Research Team members.

The data analysis, assisted by NVivo software, included:

1.1.1. **Automated data breakdown** into four sections, following the structure of the online form (see table 1.2 below)

Table 1.1.2. – Number of cases responding to each of the form questions

Name	Cases
Experience of 'speaking up' and raising concerns at work. Good and bad experiences	368
Successful factors in positive experiences / Main problems in negative experiences	190
Views and ideas on what would help to create an open and honest reporting culture in the NHS	259
Other comments	142

1.1.2. **Automated keyword text searches and word count.** Keyword searches were used to identify and (pre)code key themes. Text searches included the following: culture, media /

press, health / depression / mental, bullying / harassment, corruption, victimisation / blacklisting, retribution / reprisal, funding / finances / legal, racism / BME. Additionally, text searches and word counts were used to explore the language used by respondents and identify the terms used to describe 'speaking up'.

1.1.3. **Classification of respondents' characteristics.** Individual submissions were anonymized by the Review Team. The socio-demographic and other classifications were extracted by the information that respondents mentioned in their submissions. The information provided and other characteristics were coded according to the following attributes:

Table 1.1.3. – Description of classification attributes

Attributes	Categories
Professional role	1. Academic 2. Administration 3. Director / Executive 4. NHS Senior Medical Staff 5. NHS Management Posts 6. NHS Clinical non-managerial staff 7. Patients / Family Member / Friends / Colleagues 8. Union / Support 9. Other
Location	Regions (Office for National Statistics classification)
Organization	1. NHS 2. Private / Charity / NGO 3. Education 4. Advisory Body / Support Group / Regulator Body
Reason of submission	1. Whistleblower 2. Alleged wrongdoer 3. Whistleblowing experience 4. Whistleblowing issue 5. Submit concerns / make comments / express views 6. Other
Time frame	1. Started in 2014 2. Started in 2012-2013 3. Started before 2012 4. Unspecified / Unassigned
Type of experience	1. Positive / Mixed 2. Negative

1.1.4. **Manual thematic analysis.** This aimed to identify, explore and analyse key themes included in the submissions. The initial stage of analysis was informed by a pre-set system of codes ('coding tree') and was further amended to include themes that emerged from data analysis, presented in table 1.4 below.

Table 1.1.4. – Coding structure ('coding tree') informing the thematic analysis

Name of codes / sub-codes
• **Experience of speaking up and raising concerns at work.**
• **Implementation of whistleblowing policy**
o Knowledge / Use of employer procedures, policies
o Mediation - Alternative forms of dispute resolution
o Safeguards in reporting (anonymity, confidentiality)
o Vindicated cases
o Which organisations were involved
• **Management**
o Availability of support
o False allegations
o How was the wrongdoing dealt with
o Multidisciplinary teams
o Union & Legal
• **Outcomes for the whistleblower**
o Are they back in work, re-employed, suspended, unemployed?
o Effect on whistleblower
o Retribution
• **Overview of submissions**
o Chronology of submissions
o Lack of trust in whistleblowing procedure and speaking up survey
o Media
o Other comments
o The language used by respondents
• **Factors in positive & negative experiences**
o Negative - Main problems
o NHS Culture - Negative
o Positive - Mixed
• **Views and ideas on what would help to create an open and honest reporting culture in the NHS**
o External body
o External sources (i.e. journal articles, books, proposals)
o Support and training for doctors
o Support for individuals / whistleblowers
o Treatment of staff who are reported

1.2. Overview of submissions

The 402 cases thematically analysed for this report include only submissions from 'individuals'. Although the main submissions followed the structure provided by the online form, they varied significantly in length and style. Some submissions were quite succinct or generic; others provided extremely detailed accounts of particular incidents.

The report identifies some overarching themes and recurrent issues, using as much as possible the language used by respondents and providing a selection of insightful quotations. Verbatim quotes from respondents have been included as evidence of data interpretation and as well as for the purpose of giving participants a voice. Quotations have been amended slightly to remove grammatical errors, but in some cases minor mistakes and typos have been kept intact as evidence of the language and style adopted by respondents.

In most cases the location of respondents was not available or had to be removed by the Review Team as part of the process of anonymisation. However, the submissions which included reference to a specific region (about 80 in total) revealed a good geographical spread.

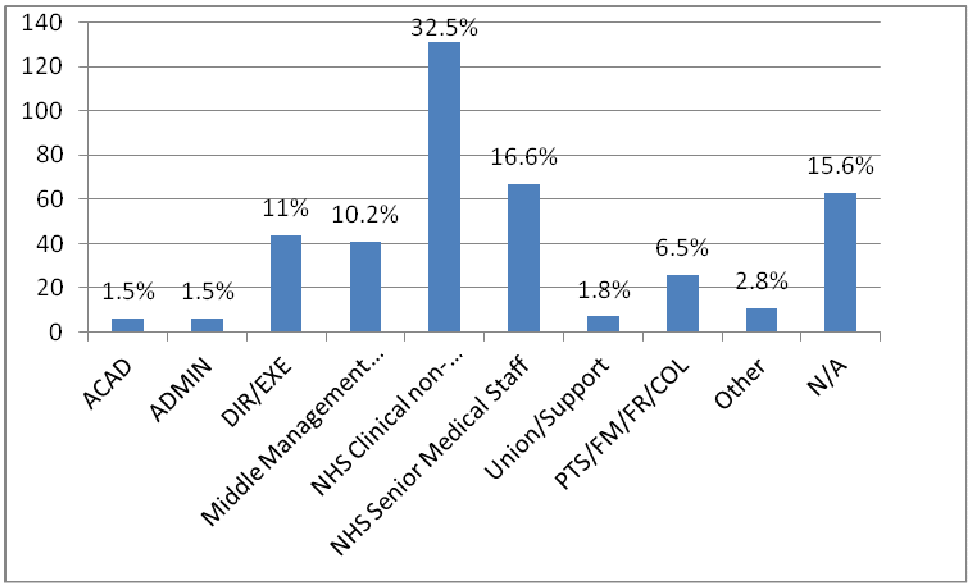
1.2.1. Professional role of respondents

The classification of data according to the professional role of respondents has shown that the relative majority of submissions (32.5%) were submitted by NHS Clinical non-managerial staff. A considerable numbers of submissions (16.6%) came from NHS Senior Medical Staff, while Directors and Executive Managers represent 11% of submissions.

Table 1.2.1. – Professional role of respondents

Role (Code)	Role (Description)	Number	Percentage
ACAD	Academic roles	6	1.5%
ADMIN	Administration, including IT	6	1.5%
DIR/EXE	Executive Board Members, Medical Directors, Directors of Nursing	44	11%
Management	Clinical and non-clinical middle managers	41	10.2%
NHS Clinical non-managerial staff	Medics (non-consultant grade), Non-managerial nurses, midwives, social workers, psychologists, professions allied to medicine and other NHS staff	131	32.5%
NHS Senior Medical Staff	Medical Consultants	67	16.6%
Union/Support	Professional Unions, Support groups	7	1.8%
PTS/FM/FR/COL	Patients, Family members, Friends, Colleagues	26	6.5%
Other	Porters, drivers, non-NHS professions	11	2.8%
N/A	Not applicable / Unspecified	63	15.6%
Total		**402**	**100%**

Chart 1.2.2. – Professional role of respondents



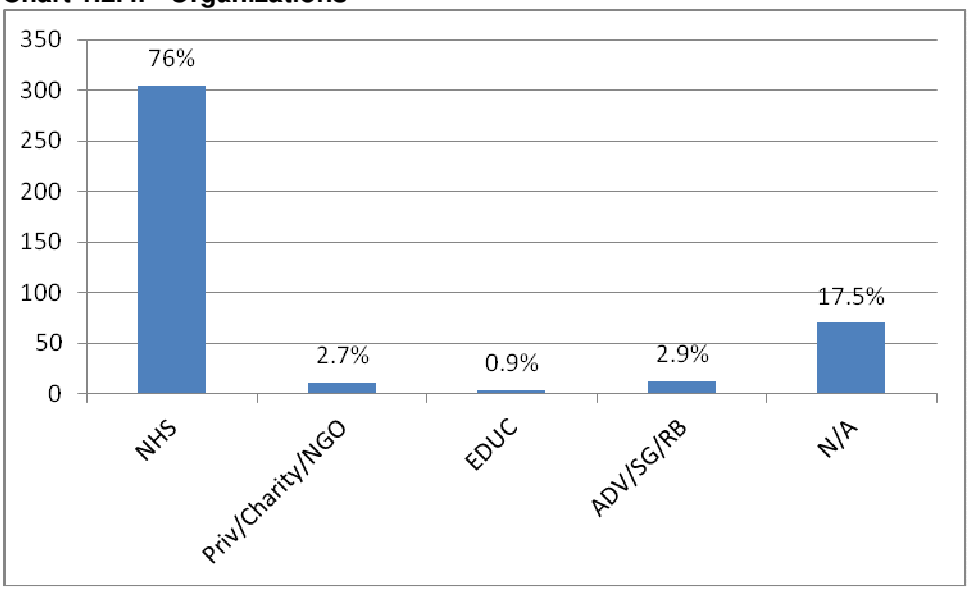
1.2.2. Organizations

Table 1.9 presents an overview of the types of organisations that have been mentioned in the submissions. The vast majority of respondents are employed by NHS Trusts or raised issues that concerned the NHS Trust.

Table 1.2.3. - Types of organizations mentioned

Code	Description	Number	Percentage
NHS	NHS Foundation Trust, NHS Hospital Trust, NHS University Hospitals, Community Trust etc.	305	76%
Priv/Charity/NGO	Private company, Consultancy, Charities, Non-Governmental Organizations	11	2.7%
EDUC	Any organization delivering training, education, research	4	0.9%
ADV/SG/RB	Advisory and support groups, Trade Union. Regulatory bodies that oversee care or standards of practice	12	2.9%
N/A	Not Applicable / Unspecified	70	17.5%
Total		**402**	**100%**

Chart 1.2.4. - Organizations



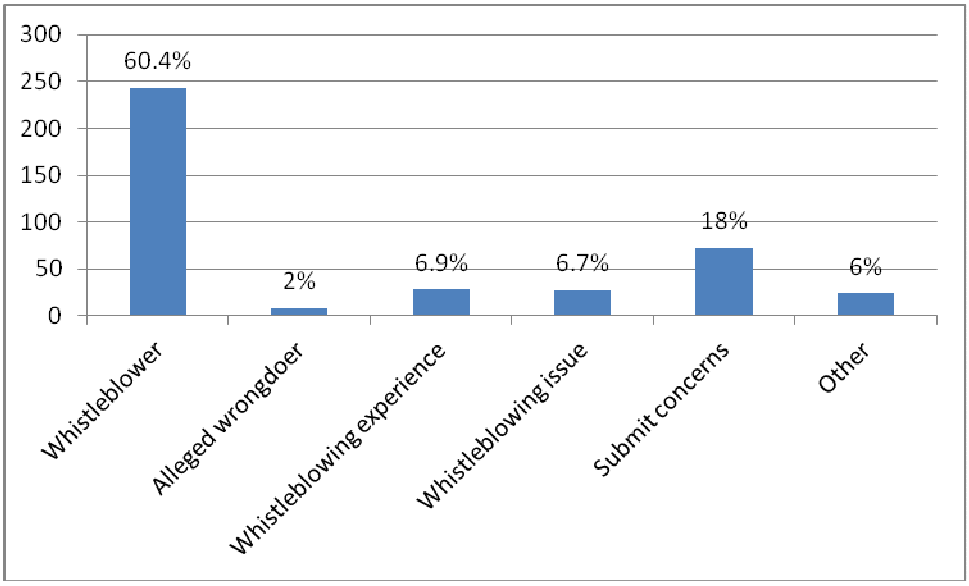
1.2.3. Reason for submission

Most submissions (60.4%) were directly submitted by whistleblowers (i.e. people who had raised a concern); additionally, 15.6% related to whistleblowing issues or experiences, while 18% of respondents took the opportunity to express more general concerns about issues in their work environment.

Table 1.2.5. – Reason for submission

Reason	Description	Number	Percentage
Whistleblower	NHS staff that has raised concerns in work environment	243	60.4%
Alleged wrongdoer	Subjects of whistleblowing allegations	8	2%
Whistleblowing experience	Involved in whistleblowing process from various positions (e.g. managers, HR, Trade Union, solicitors, Independent Ombudsman, Colleagues/Witnesses, Academic roles)	28	6.9%
Whistleblowing issue	Comments on whistleblowing. Other people who have experienced whistleblowing (e.g. partners, relatives, family members of whistleblowers)	27	6.7%
Submit concerns / comments / views	Express concerns about bullying, NHS culture, patients' care, unfair dismissal, BME issues, management, workload	72	18%
Other	Request to be interviewed, Thank-you note for treatment received in NHS, proposals/externals/suggestions	24	6.0%
Total		**402**	**100%**

Chart 1.2.6. – Reason for submission



1.2.4. Time frame of submissions

The tables below summarise information on the timeframe of the cases described in the submissions. This is based on 306 individual submissions (out of 402 in total) that refer specifically to a whistleblowing issue or experience. The submissions that refer to other issues have been excluded from the time frame analysis.

Overall - among those submissions which discussed specific cases and indicated a timeframe - 39% had started with a concern raised in 2014, 42.5% started between 2012 and 2013 and only 18.5% refer to older cases.

Table 1.2.7. - Submissions referring to specific cases by type of contributor, start date and status (ongoing/closed)

	Started in 2014	Started in 2012-2013	Started before 2012	Unspecified/ unassigned	Total
Total ongoing cases	**21**	**23**	**10**	**13**	**67**
▪ 'Whistleblowers'	19	22	9	8	58
▪ Whistleblowing (other)	2	1	1	5	9
Total closed cases	**0**	**29**	**48**	**162**	**239**
▪ 'Whistleblowers'	0	27	45	113	185
▪ Whistleblowing (other)	0	2	3	49	54
Total cases	**21**	**52**	**58**	**175**	**306**

Chart 1.2.8. - Submissions referring to specific cases percentages according to started date

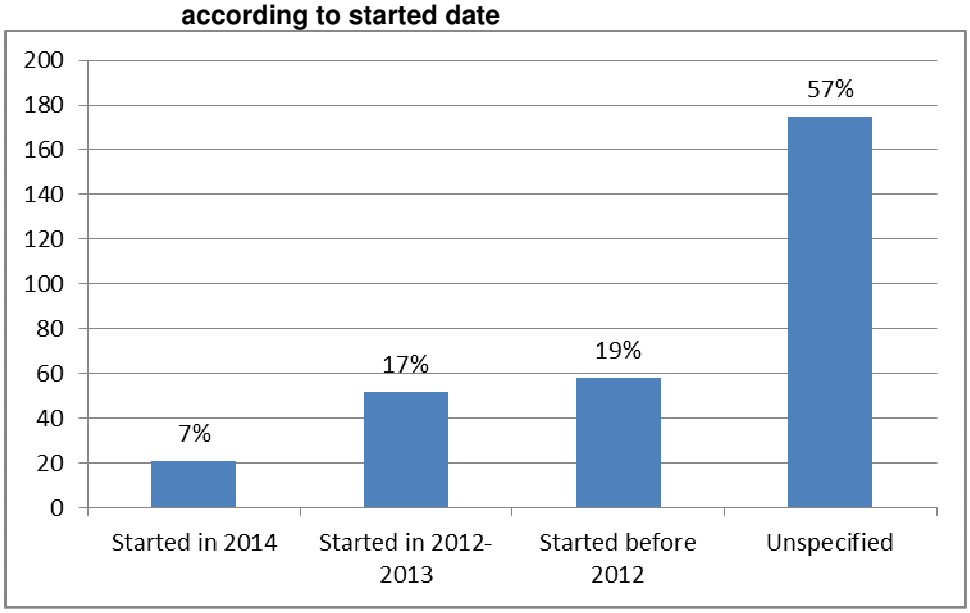


Table 1.2.9. - Submissions referring to specific cases percentages by started date (including unspecified timeframes)

	Started in 2014	Started in 2012-2013	Started before 2012	Unspecified/ unassigned	Total
Total ongoing cases	**31.4%**	**34.3%**	**14.9%**	**19.4%**	**100.0%**
▪ 'Whistleblowers'	32.7%	38.0%	15.5%	13.8%	100.0%
▪ Whistleblowing (other)	22.2%	11.1%	11.1%	55.6%	100.0%
Total closed cases	**0.0%**	**12.2%**	**20.0%**	**67.8%**	**100.0%**
▪ 'Whistleblowers'	0.0%	14.6%	24.4%	61.0%	100.0%
▪ Whistleblowing (other)	0.0%	3.7%	5.6%	90.7%	100.0%
Total cases	**7.0%**	**17.0%**	**19.0%**	**57.0%**	**100.0%**

Table 1.2.10 - Submissions referring to specific cases percentages by started date (only specified timeframes)

	Started in 2014	Started in 2012-2013	Started before 2012	Total
Total ongoing cases	**39.0%**	**42.5%**	**18.5%**	**100.0%**
▪ 'Whistleblowers'	**38.0%**	**44.0%**	**18.0%**	**100.0%**
▪ Whistleblowing (other)	**50.0%**	**25.0%**	**25.0%**	**100.0%**
Total closed cases	**0.0%**	**37.7%**	**62.3%**	**100.0%**
▪ 'Whistleblowers'	**0.0%**	**37.5%**	**62.5%**	**100.0%**
▪ Whistleblowing (other)	**0.0%**	**40.0%**	**60.0%**	**100.0%**
Total cases	**16.0%**	**39.7%**	**44.3%**	**100.0%**

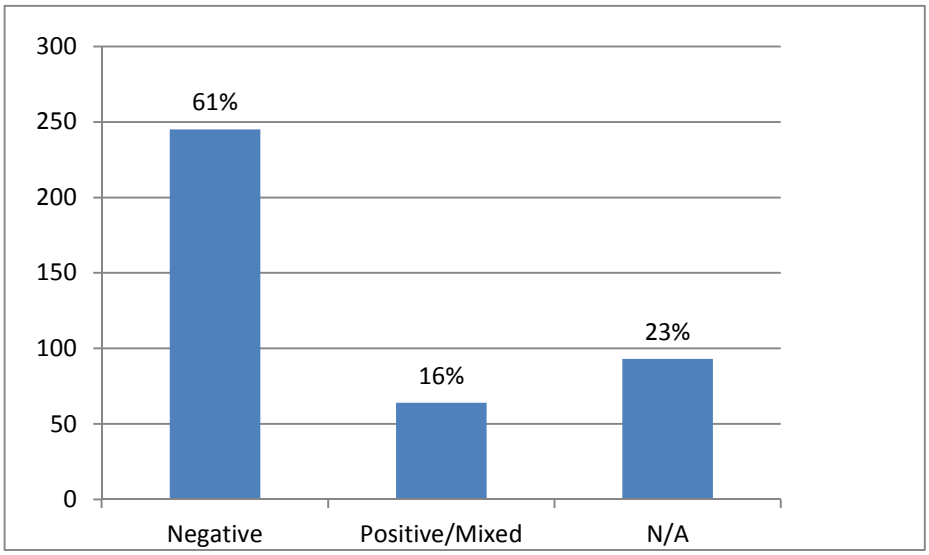
1.2.5. Types of experience

The vast majority of submissions (61%) describe overall negative experiences of 'speaking up'. Negative experiences of whistleblowing include critical accounts of NHS professional culture, poor implementation or breach of procedures, criticism of management, lack of support and negative outcomes for the whistleblower. '. There were, however, a number of more positive experiences, as well as submissions which reported a mixture of positive and negative aspects of whistleblowing process (64 submissions, representing 16% of the total of submissions). Positive experiences focus on positive culture, good knowledge of policy, internal and external support and accountability for all.

Table 1.2.11. - Experiences

Experiences	Number	Percentage
Negative	245	61%
Positive/Mixed	64	16%
N/A	93	23%
Total	**402**	**100%**

Chart 1.2.12. - Experiences



2. Experiences of speaking up and raising concerns at work

The following sections present the main factors which, according to respondents, have contributed to make their experience of 'speaking up' positive or negative. As mentioned before, within the set of submissions analysed for this report, the number of negative experiences – and related factors – was considerably larger than the positive ones. Broadly speaking, (positive and negative) factors reported fall into two main categories: factors related to professional culture and factors related to the existence and/or implementation of whistleblowing procedures.

2.1. Positive Experiences

2.1.1. Positive factors affecting 'speaking up

More than half of the positive experiences are reported by whistleblowers, while small numbers of people involved in whistleblowing cases in their capacity as managers, union representatives or regulatory positions have submitted reports which were, in the main, positive.

Among the factors reported as contributing to make 'speaking up' a positive experience, the most significant and most recurrent ones refer to working environments where 'speaking up' is welcomed and encouraged and where staff are protected from negative consequences. More generally, positive experiences include the following elements:

- **Positive Culture**
  - Integrity (e.g. honesty, impartiality, standing up for (NHS) values, culture of learning and improving).
  - Ability to listen. (e.g. empathy and genuine understanding of the experiences).

- **Knowledge of policy implementation**
  - Good knowledge of policy and existing procedures
  - Good training ('helps energise and educate staff')
  - Clear definitions of bullying and 'whistleblowing' (e.g. 'DWP guidelines are helpful in distinguishing between firm and fair management and bullying and also identify dysfunctional relationships vs bullying').

- **Availability of internal support**
  - Practical and moral support from experienced, knowledgeable, high profile and reassuring colleagues.
  - Work with a group/team rather than going alone ('gave credibility and support').
  - Direct access to specific support for all staff who need advice (e.g. HR)
  - Counselling (e.g. through occupational health; useful in dealing with effects on mental health of people involved in the whistleblowing procedure).

- **Availability of external support**
  - Good legal representation / experienced solicitor
  - Ability to access advice from 'experts'

- **Accountability** ('culture of accountability for all')
    - Support staff who made mistakes / give warning if there is a serious mistake
    - Deal with concerns without any blame.

Table 2.1 – Selected quotes on 'positive factors'

"Positive experiences result from change of behaviour or processes so that the event/behaviour doesn't recur. Positive experiences from the experience of talking out have been related to being taken seriously by senior members of the hospital management, events being dealt with fairly and in a timely fashion so that there is a ***reasonable resolution reached as quickly as possible****."*
"I think ***the updated policy makes all steps quite clear to staff*** *and also, it is very clear about the protection staff will receive if they make a disclosure."*
"I have had good experience as I report to the Director who is forward thinking, allows ***free thinking*** *and* ***encourages everyone's views and opinion****."*
"Consultants ***took me seriously****, handling was exemplary.* ***I was looked after*** *and the episode did me no harm"*
*"****Keep good records*** *if you know something is wrong, work in a team; I had no idea that writing a joint letter from […] colleagues would be so powerful!"*
"I have had success in getting staff to raise concerns through ***anonymous channels****. My philosophy is that* ***it is more important to know a problem exists than to know who identified it****."*
"We were offered ***counselling*** *through occupational health which was useful as we all suffered and at times were off sick due to the situation."*
"Good Experience: After the transition period, it all seemed positive, ***there was change and it was for the best****. It has been so far and some of us keep with the* ***positive aspect*** *of things."*
"I raised my concerns with senior management and they were listened to, a new policy has been written and there is a new process in place."

2.1.2. Good practices

Some of the submissions identify some specific good practices leading to positive experiences for those who speak up; these include:

- Focus on values, culture, value based leaders, governance and staff engagement to achieve open culture, supportive and learning culture and culture of accountability for all.
- Collaboration between Medical and Nursing Directors to examine complaints, litigation,
- Coroner's feedback on incidents on a weekly basis.
- Ask for advice from external experts
- Very close working relationships between clinicians and managerial staff.
- The Manager's Role in Resilience (e.g. primary prevention of stress, peak performance using mental wellbeing of the workforce, social engagement).
- Protection of anonymity

Table 2.2 – Selected quotes on good practices

*"By focusing on our **culture, values, leadership, governance, staff and patient engagement** we have completely transformed the Trust and we got brilliant 'Fair and Open' culture supportive and learning culture and a culture of accountability for all including the Trust Board and […] staff have raised concerns with me and I have been able to deal with all of them."*
*"The understanding of **good practice will eliminate the need for whistleblowers**, as it is expected that sharing responsibility for future success is based on everyone being 'empowered' to critique and contribute their ideas to make tomorrow a better place than today".*
*"The positive elements were that the facilitated workplace discussion did bring about **actions that acknowledged culpability** and made change based on this".*
"Number of Documented Successful cases where a fair process was followed and lessons were learned and shared (Many 1st time fixes through local informal mediation)."
*"I believe that **multidisciplinary** communication is a very important part of NHS Trust work*".

2.2. Negative factors affecting 'speaking up'

Negative factors, as emerged from the analysis of individual submissions, appeared much more detailed and specific than positive factors, as negative experiences represent 61% of the total submissions and the vast majority of experiences referring to specific cases. The negative factors affecting 'speaking up' concerned the NHS culture, poor implementation of whistleblowing policy, lack of accountability of management structure, lack of support and unbalanced resources among parties involved in whistleblowing. Feedback from participants towards management behaviour and culture was predominantly negative. The main themes are presented analytically below.

2.2.1. Culture

- **'Negative NHS Culture'**
    - **Blame culture.** (e.g. a tendency to "blame" and scapegoat rather than looking at wider system failures)
    - **Denial and resistance.** (e.g. culture of delay, defence and denial. No acceptance of constructive criticism. Resistance to change).
    - **Culture of fear** (e.g. fear of speaking up to avoid negative consequences, such as losing one's job).
    - **Bullying and harassment**. Including direct threats and intimidation aiming to prevent whistleblowing.

Table 2.2.1. – Selected quotes on 'negative culture'.

*NHS Organisations have culture of **"resist criticism"** rather than **"forensic investigation and learning"**.*
*"There exists a culture of **bullying** within the organisation that was largely covered up. For every case that comes to light, there is an iceberg of events that are simply not reported. The most commonly used phrase (including the managers) was 'there for the grace of god go us'."*
*"NHS has a **culture of bullying and harassment** that means clinicians could not raise issues in clinical care and are pressured to put targets over ethics. If there is such a culture then it is because the majority of managers or clinicians in positions of authority are driving it / managers recruited/promoted to those positions because of their ability/willingness to push this agenda."*
*"This "culture of resist criticism […] ultimately lead to [them] taking out a perpetual injunction against me. So [they] chose to **take out an injunction against me** rather than investigate my complaints. My lawyer told me that organizations often use such injunctions to silence criticism of them. The use of the Injunction against me as whistleblower is similar to **gagging clause**."*

- **'Discriminatory Culture'**
    - **Racial/ethnic discrimination**. (e.g. negative discrimination against BME staff / 'affirmative action' followed by HR)
    - **Homophobia & sexism.**

Table 2.2.2. – Selected quotes on racial/ethnic discrimination and homophobia

*"My main area of concern is that the **ethnic minority** (BME) and the foreign trained NHS staff who experience **disproportionate detriment** in response to speaking up against poor standards of care in the NHS."*
*"Most experts, leaders, decision makers are White and most staff severely punished are from BME and NHS has to look at the reasons and what lessons can be learnt and why there are hardly any BME leaders in the decision making positions and impact of **subconscious bias**."*
*"It appeared that HR were more worried about the organisation's **reputation**; the work colleague was a BME and my friend felt that took precedent over anything else. It seemed that there was more concern about the implication of "racism""*
*"I have experienced blatant **homophobia** and **racism** here in last 4 years - from senior staff mainly. Disgusting behaviour. […] No acknowledgement of internal cover up or poor practice let alone awful bullying and damage to career. I was told that witnesses that backed my complaint were lying. Disgusting!"*
"BME staff that were overseas trained do not get good induction, help support and guidance to deal with their communication problems, NHS way of working, patient confidentiality, ethical issues and so on and hence tend to make mistakes more often. They do not get support and gradually feel isolated and labelled as trouble makers"

2.2.2. Poor implementation of 'whistleblowing' policy/procedure

- **Lack of response / adequate action**
  - Trust failing to follow correctly its own processes / procedures.
  - No preliminary investigation. (e.g. early warning signs being ignored)
  - Concerns and grievances not addressed or acknowledged (e.g. no action taken, failure to investigate, to listen and to act)
  - Unresponsive escalation mechanism
  - Unwillingness by HR to address issues (e.g. to challenge Board Directors, to examine their own methodologies etc.)

- **Lack of transparency and openness**
  - Secrecy
  - 'Cover up' (e.g. 'corrupt HR advisors and Managers help to cover up processes').

- **NHS staff not satisfactorily knowledgeable about 'speaking up' policy**
  - Insufficient training and poor understanding (e.g. of Trust policies and policies that are not fit for purpose).
  - Poor communication and lack of consistent communication around key messages (e.g. financial plans, savings targets and patient care).
  - Too much paper work (e.g. "tick the boxes approach")

Table 2.2.3. – Selected quotes on poor implementation of 'whistleblowing' policy

*"The dismissal hearing was a **farce** (what the judge in my tribunal case called a **'show trial'**), with no respect for the principles of plurality, independence, and expertise."*
*"It is essential for organisations to acknowledge the **need for change**. We had reporting culture, but meaningless if no action. We felt able to report but frustrated that data and solutions did not fit into planning process."*
*"There has been **unwillingness by HR** to address the issues or give clear messages to the perpetrator that the behaviours were unacceptable. I feel that they just wanted to rid themselves of a problem rather than address it and the complainant becomes the problem."*
*"Regulators and responsible bodies failed consistently and more often took the assurances of organisations **at face value** rather than going to the source or exploring assertively in greater detail."*
*"The main problem in my view was that rather than engaging meaningfully with me to explore my concerns and consider possible remedial actions or modifications to the system, there seemed to be a **rigid defensive position** taken that precluded any potential for change and denied any problem with the system. There is plenty of rhetoric about which talks of including staff in making changes but in reality things are very **autocratic** and to my mind potentially **dangerous**."*
*"The **mishandling** of my reports, **breaches** of each and every clause of both of the Whistleblowing and the Grievance Policies, deceit, incompetence and refusal to respond on the part of all involved had already shown me that clinical concerns were of no interest to this self-obsessed organisation."*
*"The consultant's professional leave was curtailed but nobody seemed to investigate further my claims of lack of leadership, not seeing patients to their detriment and poor behaviours to colleagues. This person is still practising and **brags openly about getting away with it**. I felt I let down my […] team by whistle blowing and then **nothing changed**.*

*"I have been asked to **sign a "Whistleblowing" Policy document**. I had not been signposted to it before. Having said that the policy appears difficult to follow even I had had the courage to threaten my job. The first thing you are recommended to do is "Refer to the Framework for Personal Responsibility". As far as I can understand it this document is a top down pre-disciplinary route to get people to follow the Trust policies. It has no relation to reporting your concerns to an independent person. This appears to be **muddled thinking**."*

- **Mediation**
  - Inefficient internal mediation processes
  - Compensation offers
  - Non-disclosure agreements ('gagging clauses')

Table 2.2.4. – Selected quotes on mediation

"I was suspended after this meeting by the mediator (senior manager) saying that the way I behaved was aggressive with lots of shouting and the manager was crying throughout. Completely untrue. All that happened is that I raised some of the care issues and my treatment. The interview was taped so it was there for all the other senior managers to hear for themselves it wasn't true."

"I am one of [a number of] consultants who ultimately signed non-disclosure agreements as a consequence of speaking out about problems in the institution that I worked in. I have left the NHS and now work overseas. In summary, I pointed out gross injustices that were being perpetrated by the system and I was immediately suspended for alleged misconduct. I chose, like so many others, to take the easy road out rather than suffering years of litigation and potential abuse. Perhaps the most alarming pot of my experience was the well-rehearsed and smooth pathway that existed for eliminating troublesome doctors from the system. There were clearly two standards, one relating to managers, and the other two medical staff who spoke out."

*"A mediation meeting I had with the manager who recommended my sacking turned into a **farce** when instead of mediation she presented me with an alternative – accept an **exit package** or **be sacked**. When I raised concerns about having been bullied by a senior doctor, she said, I will not allow you to say anything negative about that doctor."*

"I was regularly offered inducements by the Trust to sign a compromise agreement, and when I refused it would be followed by threats of seeking costs against me ."

"Against NHS guidelines, the Trust asked me to sign a confidential gagging clause which they termed an "action behavioural contract" which stated I was at fault and would not speak out again. They said it was highly confidential between me and the medical director. When I refused to sign, the trust said in that case there would have to be a disciplinary case against me."

2.2.3. Lack of accountability of management structure

Feedback from participants towards management was predominantly negative. Many of the respondents believed that management regarded the medical and scientific staff as a 'necessary evil' and as 'trouble makers'. Other criticisms included that management did not adhere to their own policies and that breaches of confidentiality (in the form of revealing information to managers involved) had occurred. There was a perception that management played down complaints, as poor practice was deemed a reflection on their management skills. There was also evidence of distrust and lack of confidence in management to effectively deal with disclosure issues. Respondents in the study very rarely, if at all, believed that management were dealing with or were able to deal with disclosure in an effective way.

- **Management not taking responsibility for their actions.**
    - No sanctions for misuse of power by senior management (e.g. favouritism)
    - Managers 'closing ranks' (e.g. defensive barriers put in place to protect senior management through stalling of audit and other legitimate procedures).
    - Managers investigating cases raised against themselves.
    - Organisational conflicts. (e.g. mismatch between management agenda and clinical frontline staff).

Table 2.2.5. – Selected quotes on lack of accountability

*"From my perspective the fundamental problem is a **lack of accountability** for the people who whistleblowers complain about and the managers (often the same people) who have responsibility for these problems."*
"Accountability is meaningless when it means only describing what has been done, rather than taking responsibility for its consequences."
*"Where processes rather than individual competence is the problem, the familiar problem of those in charge of the systems **investigating themselves** arises."*
"The staff that investigate complaints / incidents are often the staff that are bullies / poor practitioners."
*"**Management being so far removed** from the problem and never coming to visit us at ground level to listen to the problems we are facing. They simply do not understand the problems as many of them are not clinicians but have corporate backgrounds."*
*"Managers within the organisation being stressed and feeling under pressure and not able to take constructive criticism, being prepared to **hide failings** or deflect away from the criticism by targeting the individual."*
*"NHS senior managers are mostly non clinical individuals with a **completely different agenda** to the clinicians and front line staff, doctors and nurses. All of the power lies with the non-clinicians who hold the purse strings. They set the tone, which does often not include compassion, kindness, room for speaking up about poor care or vocational traits that may see care and compassion prioritised above finance and targets".*

- **Process perceived as unfair by the subjects of allegations**
    - **'**Biased' investigations (e.g. 'false allegations' not being challenged, confirmation bias took over rather than looking at the evidence).
    - Unsubstantiated allegations undermine trust in the disciplinary process

Table 2.2.6. – Selected quotes on "process perceived as unfair"

"It angers me when serious allegations are made which, in my view, are false and which the Trust cannot publicly answer other than in the most general terms."
*'Whistleblowing' law is **abused for personal gain** and staff like myself are penalised and become victimised"*

2.2.4. Lack of support and unbalanced resources

- **Lack of support**
  - Feelings of powerlessness (e.g. no support and nowhere to turn to in the organisation)
  - Lack of counselling
  - No access to senior management / HR for support

- **Legal representation, financial resources & the role of trade unions and professional bodies**
  - Disproportionate amount of power and control
  - Financial inequality (e.g. limited resources, need of own financial resources).
  - Legal (e.g. access to lawyers is expensive and very costly to the average staff or patient).
  - Difficult to access legal professionals via the Trade Unions or healthcare professional bodies (e.g. access to union support necessitates membership and a delay).

Table 2.2.7. – Selected quotes on unbalanced resources

*"My experience is very negative. **I did not feel supported**. Plus when I contacted the union, the lady in charge said she could not meet up with me as she had several cases of bullying she was dealing with."*
*"**Whistleblowers are not experts in employment law** but healthcare companies have HR and legal teams on hand to advise at every opportunity meaning they have the upper hand. Finances also put employees at a disadvantage."*
*"We have been totally supported by solicitors throughout but they have **limited resources**. The Trust has open access to lawyers."*
*"**David v Goliath fight** for justice - NHS organisations appoints highly paid lawyers to undermine the Public Interest Disclosure Act and I had to fund my legal fees."*
*"The tribunals decision to dismiss my claim prior to a hearing of my case clearly communicates that if you speak out to protect your colleagues and the quality of care to your patients, not only will you lose your job, but you will have **no access to justice or redress via the Employment Tribunal**."*

3. Outcomes for whistleblower

Many respondents reported physical, psychological, emotional, professional and financial consequences as a result of 'speaking up'. Outcomes are reportedly negative for the majority of parties involved in the whistleblowing. Only a few positive outcomes have been reported mainly from whistleblowers that felt supported during the procedure and were able to maintain working relationships with their colleagues.

3.1. Effects on emotional and psychological wellbeing

- **Mental health**
    - Harrowing and isolating process (e.g. 'being ostracised by the team on line manager's instruction', little acknowledgement of difficulties or actions of whistleblowers).
    - Physical and psychological exhaustion (e.g. with long investigations, evidence and grievances)
    - Deterioration of mental health (e.g. chronic and recurring depression, anxiety, panic attacks, mental breakdown).
    - Experiencing lack of purpose and self-worth. (e.g. lack of career progression and personal development).

Table 3.1. - Selected quote on effects on wellbeing

*"I have often been so **depressed** by this experience that I have often considered **suicide**. I live in **fear** that the hospital will carry out its threat to sue me and take my home from me if I don't pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers)."*
*"The Health services managers did not think what impact, misery this has brought on me and my family. **I continue to suffer from depression** ,psychologically, emotionally, physically and financially for several years."*
"As I continue to suffer Stress/Depression as a result of those experiences which were admitted by the Trust, an application for NHS Permanent Injury Benefit was submitted by the Trust on my behalf."
*"**I am exhausted both mentally and physically** with 'investigations, evidence, grievances, whistleblowing' and this organisation and its' treatment of me; again, I reiterate, this is my reality."*

3.2. Retributions

- **Reprisals** (e.g. counter allegations)
- **Disciplinary actions.** Counter allegations are being continued even after vindication.
- **Victimisation** (e.g. bullying, persecution, harassment, racist attacks)

Table 3.2 – Selected quotes on retributions and victimisation

*"Whistleblowers are **victimised** and **persecuted** and find themselves being accused with **false counter allegations**, despite in most cases there are lack of evidence of any wrong doing."*
*"I have been subjected to **false allegations of misconduct** which following internal investigation I disproved all. Thankfully, through mid-staffs and the media coverage I kept all emails, correspondence relating to my disclosure which has been invaluable in my defence. The […] support has been **weak, reactive and I believe colluding** and if it had not been for the fact that I sought independent legal advice immediately I believe I would be dismissed today*."
*"The [regulator] also on the urgings of the trust subjected me to years of **harassment** and most of their allegations were subsequently found to be false.MY experience was extremely frustrating and efforts at improving services led to the **destruction of my unblemished reputation** and international standing. I cannot in all conscience advise anyone to whistle blow in the current corrupt atmosphere otherwise be prepared to be slandered, excommunicated and destroyed."*
*"Myself and a colleague whistleblew following our trust's voicing concern policy. We were then subjected to a **lengthy preliminary investigation** undertaken by a law firm. We were exonerated of the allegations of possible gross misconduct; the issues we raised were the same as those they then accused us of."*
*"The main means of **penalising whistleblowers** is through the disciplinary process which may lead to an oral or written warning, **suspension or even dismissal. The process is usually protracted and stressful. The victim will feel isolated and** unable to discuss matters with colleagues for fear of breaching confidentiality – itself a disciplinary matter."*
*"I was exposed alone as the **dastardly whistleblower**. The partner later admitted that she was scared of being victimised if she appeared to support me or my views."*
*"I have also seen other ways that whistleblowers are attacked, often by finding minor errors that can be magnified to use against a whistleblower. I am aware of cases where managers have gone through a doctor's waste bin or document shredder bin, or searched their office at a weekend to try to find some scrap of evidence of an error to magnify and justify suspension. When no evidence can be found, **lies are fabricated** to allow suspension of an employee. These can take so long to disprove, that by the time the employee has been vindicated it is claimed that their job no longer exists or that their period of suspension means that they are deskilled and cannot be re-employed. Careers can be destroyed in that way."*

3.3. Specific impact on employment/career

- **Positive outcomes**
  - No career damage (e.g. continue working at the same position).
  - Praise
  - Vindicated cases (e.g. of unfair dismissal, bullying, false allegations of misconduct) following (internal and external) investigations and Employment Tribunal proceedings.

Table 3.3.—Selected quote on positive outcomes

*"I had no consequence for raising legitimate concerns - quite the opposite, I was **congratulated** by my external assessor for doing so at my annual trainees appraisal. I now use my experience to assist in the training of junior doctors on how to raise concerns and keep your job."*
"These concerns were vindicated by subsequent inquiries that were triggered as a consequence of what the management did to us. They fabricated POVA allegations against us and we were told to leave our posts immediately. We decided to fight back and we had massive support from doctors, admin staff and, of course, our nursing colleagues. Our plight reached important people in government and, after 7 weeks they were told to get us back to work."

- **Negative outcomes**

The majority of whistleblowing cases discussed in the submissions result in dismissal or removal from team and relocation to another position. In other cases, whistleblowers have decided to resign from NHS when they can get alternative employment offers or retire and terminate their career.

- The main negative outcomes on whistleblowers' career / employment are as follows:
  - Detrimental outcome on professional standing and career progression.
  - Suspension / Dismissal ("constructive dismissal")
  - Blacklisting / Stigma of dismissal
  - Relocation to another post / Trust (e.g. referred to as "displaced team")
  - Resignation (e.g. as personal choice or citing constructive dismissal)
  - Vindication does not necessarily lead to reinstatement of good working relationships.

Table 3.4.—Selected quotes on career loss

*"Whistleblowing it feels more apt to say **end my career**!!"*
*"Nearly all NHS whistleblowers, once dismissed, never return to their workplace. Very few continue to work in their field of expertise and even fewer manage to secure permanent posts. This is because of existence of **blacklisting** within the NHS. There is of course in addition gradual loss of skills once being unemployed. For many, only option is to **leave the country** and look for work in other parts of the world."*
*"I have been unable to secure employment within the NHS since my dismissal as a result of what I consider to be possible **'black-listing'** within my NHS Electronic Staff Record."*
*"Outcome: **Suspended from work, dismissed.** Aborted employment tribunal. **Now unemployed on benefits."***
*"I lost my career and now work [part-time] on the minimum wage facing **poverty** in old-age."*

*"I'm not the only one [who] resigned in our Hospital due to [suffering] discrimination and victimisation most of us are member of the **BME** who was been **targeted until we resigned** due to work related stress and anxiety."*

*"We have the freedom to speak but we will be **unemployed**."*

*"Getting a job with the **stigma of dismissal**, especially when you are in the newspapers, is essentially impossible. If you can find one, you have to accept a temporary locum post, usually at a lower grade. I had to struggle from one locum to another, usually at much lower grade than I was used to and doing quite different work, till this job came up. One of the managers at NHS Trust where I now work apparently Googled my name, and remarked along the lines of, 'Do we really want this sort of person?' The job agency I was registered with was told by one of the other managers, 'We know he is looking for a job, and we definitely don't want him'*.

"*Making protected disclosures in the NHS has **cost me my career**. I have been unable to obtain work in my own field since the NHS **blacklisted** me. I do not receive "unemployment benefits". The bank repossessed my house because the NHS took my job rendering me incapable of making my mortgage payments. […] I get food from the food bank."*

"I have now been **scapegoated**, and will not be returning to work".

"I eventually resigned and lodged an Employment Tribunal claim and whistleblowing claim. I was exonerated with a full apology"

"It's not that suspension shouldn't happen, but repeated outcomes where the person was vindicated could be cause for concern."

"This has caused me huge distress as my career has been nearly in tatters from taking the right course of action and being vindicated. No one have ever thanked for my integrity and action."

4. The language used by respondents

4.1. Words used to describe 'speaking up'

The various words respondents use to describe 'speaking up' and characterisations attributed to whistleblowers are presented in Table 4.1. Some respondents felt that many of the terms and language usually associated to speaking-up has a negative connotation, as exemplified in the quotes presented in Table 4.2.

Table 4.1. – Most frequent words used to describe 'speaking up'

Words	Cases
To raise concerns / issues	378
To report	330
To whistleblow (including to whistle-blow, to blow the whistle)	284
To pointing out errors	144
'Speak up', 'speak out'	129
Take out / lodge a grievance	64
To escalate concerns	56
To disclose	43
'Talk out'	41
To expose wrongdoing / failures / breaches / flaws	36
Voicing concerns	36
To expose failings / breaches / flaws	8
To "bad mouth"	1

Characterisations attributed to whistleblowers for raising up concern include the following: "troublemaker", "snitch", "back stabber", "collateral damage", "watchdog". These characterisations are indicative of bullying practices and victimisation that whistleblowers undergo as a result of speaking up.

Table 4.2. – Selected quotes on language used to describe 'speaking up'

*"I believe to begin with, no disclosure policy should be titled 'whistleblowing.' The **negative connotations** and the urban translation of whistleblowing means that it is no longer, nor has been for a long time, a suitable title that is free from interpretation. It is a slang phrase and as such is unprofessional (The urban online dictionary has **sexual interpretations**.)"*
*"**"Speak up"**, **"Speak out"**, **"Whistleblower"**, **"snitch"**.... Part of the problem is the language, the bad behaviour in the NHS. The aberrant manner in which people conduct themselves - beating staff over the head with every little incident... and those horrible incident forms where "i've discussed with the clinical supervisor". That's bullying. Why can't you just speak - normally?"*
*"Anyone who blows the whistle is seen as a **snitch** and is punished."*
*"Staff colluded together that "publicity would be poor" how could I **"bad mouth"** my own Trust and that I would lose my job and eventually I did."*

*"People made judgements about me as a **troublemaker** and for managers it seemed the easiest way to address problems was to get rid of me, anything else was too complicated."*

*"Change the name Whistle Blowing to **Raising Concern Champions**."*

*"I have been smeared with derogatory comments not only from colleagues but the Trust health services managers also. I have been called a **"watchdog"** by General Manager, a definition of whisleblowing and raising concerns*."

*"I was upset at this meeting because I was called a **"reluctant witness"**, a very difficult thing to be called when you have exposed yourself to the Whistle Blowing policy. I was called a reluctant witness because I had not named individuals who had made inappropriate comments to me."*

*"I was exposed alone as the **dastardly whistleblower**."*

"To clarify, I did not 'whistleblow' and the word to me at the time meant only if I took my concerns out into the public domain/media. I was simply raising my concerns because of my [particular] dilemma. I did not know, nor was I provided with the policy document 'freedom to speak' that existed within [the trust]"

4.2. Frequent words in the submissions

A broader counting of the words used in the submissions is presented in table 4.3. Although some of the most frequently used words are simple and predictable reflection of the issues being discussed (e.g. concerns, experiences, work), others are indicative of the main issues and concerns identified by respondents; e.g. concerns over the role of 'managers', bullying, (lack) of openness and support .

Table 4.3. - Most recurring words in the submissions (references)

Word	Count	Similar Words (included in the count)
Concern	4307	concern, concerned, concerns
Manager	2957	Manage, manageable, managed, management, manager, managers
Whistleblowing	2893	whistleblow, whistleblowed, whistleblower, whistleblowers, whistleblowing, whistle, blow, whistle-blow
Staff	2892	staff, staffs
Raising	2787	raise, raised, raises, raising
Trust	2615	trust, trusted, trusting, trusts
NHS	2487	nhs
Working	2485	work, worked, working, workings, works
Patient	2434	patient, patients
Report	2031	report, reportable, reported, reportedly, reporter, reporters, reporting, reports
Experience	1840	experience, experiences
Investigator	1623	investigate, investigated, investigating, investigation
Care	1475	cared, cares, caring
Support	1425	support, supported, supporter, supporters, supporting, supportive, supports
Cases	1366	case, cases
Nursing	1321	nurse, nursed, nurses, nursing
Issues	1251	issue, issued, issues
Health	1242	health
Timings	1232	time, timed, timely, times, timing, timings
Organising	1151	organisation, organisational, organisations, organise, organised, organisers, organising
Review	1139	review, reviewed, reviewer, reviewers, reviewing, reviews
Culture	1119	cultural, culturally, culture, cultured, cultures
Help	1108	help, helped, helpful, helping, helps
Need	1068	need, needed, needing, needs
Speak	1039	speak, speaking, speaks
Director	1026	director, directorate, directorates, directors
Inform	1025	inform, information, informative, informed, informing, informs

5. The coverage of 'whistleblowing' in the media

There is only little evidence in the submissions that whistleblowers seek help and support through media and public awareness. Whistleblowers prefer to abstain from media coverage and address legal procedures.

Indeed, in many submissions the media are described as having a negative role, with NHS staff involved in whistleblowing cases experienced media coverage as public defamation. Some reportedly underwent constant media scrutiny and were portrayed in what they considered as unfair and sensationalist fashion. Media coverage is also seen as provoking multiple negative and inaccurate comments on social media.

Table 5.1 – Selected quotes on whistleblowing coverage in the media

*"The only thing I have not done is go to the media although people have repeatedly said I should. I haven't because I thought it best to go the proper **formal routes** thinking there would be **justice.**"*
*"Tried, and found guilty without trial by media and certain individuals. The **public defamation** of character and publication of what are not his genuine personal values and human morals within the press and social media."*
*"Despite the findings of independent investigations, **sensationalist media stories** have unfairly threatened public confidence in our clinical services. A combination of cowardice, indifference and **unbalanced media reporting** is continuing to ensure that justice is not being done."*
"I think it is important to understand that, in the current NHS climate, the moment anyone gains the sobriquet of "whistleblower" they immediately become unchallengeable and unassailable. The public seem to want black and white answers – good guys and bad guys – and the media go along with this and consequently never delve below the surface."
*"I feel that some of the **media concentrates too much on 'whistle blowing'** and not on raising concerns using appropriate Governance processes. I feel that the message is wrong and people may consider whistle blowing to be the first line to take? I consider whistle blowing to be the last line*."

6. Views and ideas on creating an open and honest reporting culture in the NHS

Individuals were asked to express their views on "what would help to create and open and honest reporting culture in the NHS". Many respondents welcomed the creation of an 'Open and Fair Culture' of transparency, support and accountability in the NHS, but often failed to explain how that might be achieved. The importance of appointing an independent external regulatory whistleblowing body and independent mechanism for raising concerns was highlighted by many respondents. Other suggestions to create an open and fair NHS culture included creating integrated internal processes, training and education of staff in dealing with whistleblowing issues as well as proposals for increasing transparency, equality and diversity.

The main themes identified from respondents' suggestions include:

1. Revision of NHS management and culture
2. Clear policies and processes on reporting concerns
3. Whistleblowing processes be independent of the NHS
4. Support for whistleblowers
5. Training and education of staff in whistleblowing policy
6. Promoting NHS Cultural Change

6.1. Revision of NHS management and culture

Management and restructuring of management was seen as one of the most important aspects of creating an "open and honest reporting culture in the NHS". Some respondents suggested that managers should be more accessible to clinicians and those staff providing care. Managers should also be accountable when failings occur and should take legal and financial responsibility. Some of the suggestions made on how managers could contribute to a more open and honest reporting culture include:

- Senior Managers should conduct "walkabouts" of clinical areas.
- Managers should encourage staff to feedback concerns.
- To avoid conflict of interest managers should not hold multiple roles within the organisation.
- When managers fail to act on a disclosure they should be held accountable and this should include enforcement of criminal and custodial sentences.
- Staff should have open and direct access to senior managers in the NHS
- Managers should be visible in supporting staff and understand why concerns are being raised.

Table 6.1 – Selected quotes on revision of NHS management and culture

*"By default **surgeons should be banned from occupying multiple positions** in various organisations: the same person should not be a RCS representative and a programme director and clinical lead and so on and so on….."*
*"Unless the management, including those at the highest level, are held **accountable** for any harm caused by not acting on things which have been reported but not acted on effectively, then there is little or no chance of people being willing to report things. By accountable, I mean financially or criminally liable, not just a bit of public hand-wringing by way of press release saying how sorry they are to patients/relatives and that "lessons have been learned".*

6.2. Clear policies and processes on reporting concerns

Clear policies and processes on reporting concerns should include:

- Transparent, open, and objective action (e.g. Meetings should be audio recorded, minutes of meeetings should be shared with all involved parties)
- Clear timeframe
- Report back to staff that raise concerns
- Anonymous report

Table 6.2 – Selected quotes on 'clear policies'

*"Why does each Trust have their own policy rather than a **generic approved policy** that is clear and user friendly?"*
*"Complete **transparency** in trusts: All **meetings should be audio recorded** by default and copies given immediately to all parties as minutes of meetings are changed significantly when compared to what transpires in the meetings."*
*"**A mechanism for feeding back to staff** that raise concerns would be useful, indicating how they are going to investigate the complaint and giving some kind of timescale for resolution."*
*"The option of being able to be kept **anonymous** when raising concerns would encourage a lot of people."*
*"Being able to report **anonymously** and to have a place of safety for someone to raise concerns are two vital components to openness."*
*"A written detailed and balanced **response to my initial audit** clearly stating what was validated and what was not validated about the audit. **A stated timeframe** by when if no action had been taken another threshold would be reached at which point it would be appropriate to escalate further if there is not agreement reached that the concern has been adequately addressed - an independent consultant being involved."*
*"The organisation should have an **internal mediation mechanism** to attempt to resolve the issues. Not all concerns are well-founded. Not all concerns are capable of being resolved with given resources etc. Nevertheless no concern that indicates genuine patient risk should be allowed to go unresolved."*

6.3. Whistleblowing processes be independent of the NHS

There was considerable discussion about the importance of involving independent regulatory bodies in the management of disclosure by whistleblowers. Much of the discussion about this centred on the need for external and/or independent supervisors and processes. This need for independent adjudication arose from a distrust of managers, distrust of processes which regulate whistleblowing practice and concern that the treatment of whistleblowers was biased and prejudicial.

Suggested composition and structure of independent bodies include:

- Non-partisan regulator (e.g. an objective supervisor to oversee whistleblowing processes and who would have power over Trust boards and the GMC, for example a judge).

- External regulator (e.g. regulator of whistleblowing processes to be completely independent of healthcare).
- Anonymous hotline for whistleblowers.
- Involvement of lay people (e.g. composition of the group might include volunteers or members of the general public to oversee procedures are properly conducted).
- Support for whistleblowers should be independent of the organisation and of Trust involvement.

Table 6.3 – Selected quotes on independence of NHS whistleblowing processes

"Trusts cannot be left to mark their own homework"
*"A **designated member of the Trust Board** should be responsible for whistleblowing issues within the Trust and answerable to the Board….."*
*"I think you need an **ombudsman** of a judicial or completely non-partisan mold who acts and has judicial powers over the trust boards and the [regulator].This person should really be a sitting judge or at least a retired judge."*
*"A **TOTALLY independent body** who would investigate reports with 100% guarantee that the source of the report would not be identified."*
*"Any **investigatory HR personnel should be central and not local.** Chief executive should not be able to choose the investigator but a central place should make that decision. The whistleblowing case should be resolved before the employer turns it to employment issue."*
*"I believe an **'Early Intervention Scheme'**, which has regulatory intervention and enforcement, will assist in creating an open, honest and reporting culture within the NHS."*
*"I think that when a nurse is first asked to attend a disciplinary hearing that **a solicitor should be present** and that experienced staff run these hearings."*

6.4. Support for whistleblowers

Respondents often mentioned how important it was that those who were involved in disclosing malpractice or other problems should be supported by the organisation and that loss of finances, health or employment should be compensated for. There were suggestions that those who disclosed serious concerns were often victimised, suffered considerable ill-health, loss of employment and were generally unsupported. Recommendations which might help whistleblowers through the process include:

- Practical support mechanisms (e.g. for individuals made redundant as a result of whistleblowing, to help them finding alternative employment, make financial support, available, allocation of a "support buddy" to those affected)
- Ensure reaction to whistleblowing is sensitive and those who disclose malpractice in "good faith", receive no negative reaction
- Whistleblowers should be protected from detrimental treatment as a result of their disclosure and there should be early intervention to ensure this happens
- Healthcare organisations (e.g. CQC) and NHS Human Resources must be able to demonstrate that whistleblowers have not suffered any detriment.
- Internal mediation mechanism

Table 6.4– Selected quotes on support for whistleblowers

*"….a completely independent **staff support body**, that is open and accessible to all staff which has the powers to protect staff from any form of detriment. Without this body you will never get to the truth of bad culture and behaviours…"*
*"The most important thing is to provide a safe space within organisations for individuals to report bullying. This may be to a peer initially who might guide them and support them through the process of reporting and/or resolution. It is crucial that victims of bullying are given support and **made to feel that they are being taken seriously**. The fear of reprisals has to be removed to enable those experiencing bullying to feel confident in reporting their concerns."*
*"A SSC [Staff Support Commission] should scrutinize how those who raise concerns are treated, would listen to their stories, would see whether they have been subjected to unfair disciplinary procedures, and would see whether they got their job back if their concerns had been vindicated after suspension or dismissal. The SSC would oversee **an award scheme for whistleblowers**."*

6.5. Training and education of staff in whistleblowing policy

All NHS staff should receive education and training in whistleblowing procedures and practices.

- Training of staff on how to make correct use of whistleblowing policy. (e.g. "training in disclosure of concerns should be mandatory")
- Training of managers on whistleblowing issues, policies, procedures and impact assessment.

Table 6.5 – Selected quotes on training and education

***"Disclosure as a professional** action should be encouraged and added possibly to **mandatory training** as a means to promote the use of the action…"*
"I believe annual or biannual training in key NHS policies around dignity at work and equality and diversity should be compulsory for most senior managers."
"Give all managers training on listening to staff, Whistleblowing and avoiding bullying in the NHS."

6.6. Promoting NHS Cultural Change

Promoting NHS Cultural Change with reinstatement of a culture of disclosure and awareness. It was suggested that NHS cultural values should include:

- Zero tolerance (e.g. for any bullying, victimisation, harassment, discrimination, racism and sexism).
- Protection of ethnic minorities (e.g. BME representation in Trust Boards)

Table 6.6 – Selected quotes on promoting NHS cultural change

*"**No negativism. No retaliation. No bullying. No detriment. No sacking**."*
*"Trust Board must have **senior leaders who are from BME background**. This must reflect the ethnicity of the Trust or CCG."*

"I also think that a system could be put in place for all Trusts to engage a staff member as an ***Ambassador for Cultural Change****. They could be the first point of contact for staff who wish to whistleblow safely".*

"I do fully endorse having a policy and raising awareness of how to use it but feel the emphasis needs to be moved to changing the culture. Whistle blowing does not bring about a cultural change. ***Raising concerns needs to become normal, 'this is what we do around here'****.*

"Whistleblowing is an action which cannot be viewed in isolation and necessitates being ***reviewed in the context of the wider NHS culture*** *and behaviour."*

7. Conclusions

The 402 submissions analysed for this report present very rich information on the views, perceptions and experiences of a broad range of NHS staff, medical professionals, managers and other stakeholders. Although emerging from a self-selected sample - thus, by definition, not necessarily 'statistically representative' - the findings presented in the previous sections appear quite specific and consistent in terms of key trends and issues raised by respondents with regard to reporting within the NHS.

The importance of organisational culture

Most respondents identified organisational culture as key factor in how whistleblowing is dealt with. This aspect was discussed more frequently and strongly than specific procedural issues. Indeed some submissions highlighted how whistleblowing procedures need to be discussed and reviewed in the context of the wider NHS culture.

Positive experiences of whistleblowing reported in the submissions were usually related to good knowledge of policy and implementation of existing procedures, but also associated with a culture of openness, support and empathy. Some respondents thought that the implementation of new policies on whistleblowing brought optimism into the NHS and enhanced positive relationships between NHS management and staff.

However the majority of submission discussing NHS culture in relation to whistleblowing referred to a culture of fear, blame and 'scapegoating'. This would result in many NHS staff refraining from raising concerns in fear of retributions and bullying and under the threat of constructive dismissal. Many felt that those who raise a concern – either internally or externally – are often seen as 'troublemakers' or 'back stabbers'. In particular, the term 'whistleblower' was often described as having a very negative connotation and some respondents suggested different words should be used.

Implementation of procedures and the role of managers

Many submissions referred to inadequate implementation of existing internal procedures. These included cases closed or ignored without being properly investigated, but also breaches of confidentiality as well as other breaches of policies and procedures (e.g. heavily redacted transcripts, whistleblowers not informed of the outcome of an investigation, perceived biased composition of internal commissions).

A significant number of submissions included strong criticism of managers at different levels of the NHS structure. According to many respondents, managers who are subjects to whistleblowing often go unpunished (or promoted) and some argued that those managing internal procedures often collude to protect NHS 'upper ranks' from exposure.

According to some respondents, whistleblowing procedures can be abused and made into an array of allegations and counter-allegations that leads to victimisation of all parts involved.

Outcomes of whistleblowing

Most submissions describe whistleblowing as having negative effects in terms of career. The general perception is that those raising a concern are usually not rehabilitated in the working environment,

rarely redeployed within NHS departments and more often dismissed. In other cases, whistleblowers decide to resign when they can get alternative employment or retire.

Some respondents argued investigations are often turned against the whistleblowers, who are subsequently scrutinized and subjected to unfair disciplinary procedures.

Negative effects of whistleblowing, as discussed in the submissions, include mental health and family life. Many respondents described high levels of work-related stress, depression and mental health issues due to bullying and victimisation following whistleblowing. Similar outcomes often affect also alleged wrongdoers and other parts involved (e.g. colleagues, witnesses, and family members).

Creating an open and honest reporting culture

There was sometimes an absence of practical recommendations on how to create an open and honest culture and often respondents did not answer this last question in a very detailed way. However, some key areas of intervention can be consistently identified.

Firstly, respondents longed for a more active promotion of cultural change within the NHS as a whole and amongst managers in particular. This could be achieved through internal campaigns as well as specific training opportunities. Several respondents also thought training was also needed to ensure better knowledge of existing policies and procedures on whistleblowing, both amongst managers and staff.

Several respondents called for a more effective implementation of existing procedures, whilst others saw the need for better internal regulations, based on more clear and effective processes and leading to specific outcomes in a transparent way. Specifically, some respondents called for more accountability among managers, clearer time-frames, better protection of whistleblowers and their anonymity and the establishment of advice and practical support mechanisms. A larger role of external regulators, independent organisations and ‘lay people’ was also presented as an effective strategy to ensure a more ‘independent’, ‘non-partisan’ management of whistleblowing.