Whistleblowing and candour in the NHS

Kingsley Napley

Response to the Department of Health Consultation, January 2011

Kingsley Napley LLP are a firm of solicitors. We have a team that specialises in clinical negligence acting exclusively for Claimants. We have a wide range of experience stretching back over 20 years.

We are pleased to comment upon the Department of Health paper for consultation *"The NHS Constitution Whistleblowing"* and fully support the aims to empower NHS staff to *"speak out and protect patients or raise other issues concerning NHS organisations, without fear of victimisation. Giving front line staff the ability to respond to systemic problems in the NHS."* (Paragraph 5).

We also applaud the aims set out in paragraph 6 in particular the provision of *"a safe and independent authority to whom they can turn when their own organisation is not listening or acting on their concerns"*.

In our consultation responses we have commented upon the proposed amendments but we have also highlighted that the intended effect of the proposed amendment outlined in paragraph 11 will not be achieved with a further simple acknowledgment that the principle of *"mutuality"* mentioned in paragraph 8 of the consultation paper must extend to a duty on *"self"*. Our view is that combining the whistleblowing amendments with a clarification that the duty extends to every individual's responsibility to report their own wrong doing could achieve a radical culture shift within the NHS. The aim of this paper is to outline why we hold these views and to seek to argue that this subtle shift could have far reaching effects.

The new expectations and commitments are good but do not, in our view, go far enough. In essence this is because the proposals focus on *"others"* rather than *"self"*. It is accepted that there has to be a mandatory system of reporting but we suggest amendments to the wording which would highlight a parallel duty of candour (something that Claimant solicitors and AvMA have long campaigned for as a corporate duty). We would argue that, in many ways, this does not represent a new right or responsibility but is an obvious clarification. Our starting question is why should a practitioner within the NHS have a higher duty in relation to others than the duty they have to discharge in relation to themselves? It is our view that only when there are no double standards within the system will the culture shift. We endorse the proposed amendment to the handbook to the NHS constitution to encourage employees to *"set an example to your colleagues in your day-to-day activities by questioning behaviours and practices that you believe may not be right, appropriate or lawful"* but question whether this behaviour can be delivered without an individual commitment to apply the same rigour to own practice.

We appreciate that there may be perceived fears of the duty of candour but we believe that these must be overcome to achieve the desired shift within the NHS. The example of Mid Staffordshire is interesting in that the evidence suggests that staff knew how to whistleblow (80% per paragraph 17); the question is why didn't staff whistleblow? If personnel had felt an individual responsibility to hold themselves accountable perhaps one or more would have had the courage to say *"I don't think I have provided a good enough service".*

In the light of the example given above, we agree that the relationship with the employer is the right place to start. As lawyers we have some experience of the duty of candour and are bound by it. It has evolved because lawyers have to hold the balance between the responsibility of partnership (i.e the relationship with peers) and the responsibility to the client (which is a fiduciary relationship and has to come first and foremost). Government is often keen to use the language of partnership but to be a partner you have to accept the responsibility for your own actions and to do that means you have to be willing to admit to your mistakes.

This leads on to another area within the consultation paper that we wholeheartedly endorse, namely the support structure that is anticipated to make the process meaningful. We believe that this structure is absolutely essential to support the employee and to ensure the ability to learn from mistakes, whether they be mistakes with consequences which give rise to tortious claims or mistakes without consequences.

The NHS needs self-esteem and self-respect. It is difficult to know how to engender those qualities at a systemic level in a way that permits everybody to feel pride in their service. We suggest that the answer is not to wait for the whistle to blow but rather to encourage those within the NHS to ask themselves searching and challenging questions and provide them with the support required to make that process meaningful. A contractual *"right to do the right thing"* and an appropriate support structure would give measurable benefit to the whole system.

We note the language of the consultation paper and in particular that the word *"malpractice"* is often used in place of the word *"negligence"* to imply wrongdoing. In relation to the wording proposed in the amendments we have made suggestions in our response to the consultation paper but to enlarge upon this: any ambiguities in language will lead those within the system to err in favour of non-reporting. It is therefore our view that the language should be simplified. The expectation/responsibility could be expressed in terms of *"If you have a concern about malpractice or wrongdoing in relation to what you have done or what anyone else has done you must share these concerns with…."*.

We believe that the language used is important. The language of whistleblowing tends to be negative. It is our belief that the problem that needs to be acknowledged is the conflict of interest (protecting the NHS/practitioner versus protecting the public/patient in a situation where a wrong or perceived wrong has occurred). The simplest place to start is with the Hippocratic Oath which puts the patients first and therefore must be synonymous with a duty of candour. By using different language the responsibilities can become those of the good practitioner rather than the weapon to be wielded against the failing. Our view is that the language that is currently used evokes telltale and playground politics. More mature language that permits intelligent interpretation would guard against dumbing down and belittling the stalwarts of the NHS i.e "reporting of concerns".

As Claimant lawyers we see examples, albeit relatively rarely, where excellent practitioners have admitted an error to a patient or patient's family straight away. Usually they have immediately arranged for appropriate support for the injured Claimant. We are not aware of these steps provoking anger from colleagues. On the contrary, in our experience, these professionals tend to be highly respected. They have also been the professionals who have managed to retain the respect and trust of family (in spite of the error) because of their frank admissions. These examples show excellent clinical leadership and deliver swift resolution for all involved in what, we recognise, is a distressing process for NHS staff as well as Claimants.

There have been significant strides over the years. Internal processes have been improved. There is plenty of evidence of good practice that is helping to reduce the cost to the public purse of legitimate compensation claims. For example, good Serious Untoward Incident Reports provide experienced lawyers with the wherewithall to arrive at appropriate and speedy resolution of distressing claims. This is cost effective because cases are often resolved at the pre-action stage.

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If those reporting adverse events are supported it permits experience to be shared and the many pockets of good practice to become more widespread. People within the NHS would become unafraid of the so called *"blame culture"*. It is our hope that the shift would also ensure that those within the NHS are unafraid of any potential negligence action and we would wish a culture to evolve in the NHS where service providers were interested in learning from avoidable mistakes or 'near misses'.

We believe it is time to acknowledge that the legal process is serving the same public as NHS. We would like to see an acknowledgment that the law of tort should only be seen as a tool for delivering solutions where, despite the best efforts of the committed people within the NHS, things have gone wrong in a way that is avoidable and accountable (because of the consequences).

Encouraging practitioners within the NHS to embrace a duty of candour as well as the responsibility to report concerns/whistleblow would begin to see a shift in the way that the NHS views mistakes and lead to a genuine abandonment of the fear of frankness.

Training needs to be provided to those within the NHS about what is required to establish a case in tort. There is a perception that cases are *"constructed"*. In fact a tough legal test is applied to the established facts and an objective decision reached as to whether or not the standard of care has been breached. Our view is that it is necessary to educate those within the NHS to remove the fear of litigation.

To summarise: There is much within the NHS that is very positive. We are keen to see a joining of the dots of good practice. The consultation questions are all aimed at addressing systemic failure and cultural issues within the NHS. In our view reinforcement of the need to raise concerns/whistleblow combined with a duty of candour would go a long way towards achieving this.

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