

DUTY THE CARE OF

of Healthcare Professionals



Practical advice on the duty of care of healthcare professionals and their employers and what we must do to help protect patients and staff



Roger Kline with Shazia Khan

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Practical advice on the duty of care of healthcare professionals and their employers and what we must do to help protect patients and staff.

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The Mid Staffordshire Hospital Public Inquiry Report exposed deep failings at one hospital, but concluded that those failings could recur elsewhere. This practical handbook advises staff at every level about how, collectively and individually, to handle pressures that could compromise good care standards. Underpinned by an understanding of the law, and with links to additional information and resources, it is designed to help staff uphold standards of ethical behaviour and professional accountability, and their duty of care to patients, when they feel these may be in danger of being undermined by other pressures.

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with Shazia Khan

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Public World works with clients and partners to support sustainable development, better quality of life and social value by improving jobs, livelihoods and productivity in democratic ways.

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Preface

“The evidence gathered by the Inquiry shows clearly that for many patients the most basic elements of care were neglected.

Calls for help to use the bathroom were ignored and patients were left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid.

Patients were left unwashed, at times for up to a month.

Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding.

Staff failed to make basic observations and pain relief was provided late or in some cases not at all.

Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards.

The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.”

[Independent Inquiry into care provided by Mid Staffordshire Foundation Trust January 2005 – March 2009](#)

The evidence gathered by the Francis Inquiry into up to 1,200 unnecessary deaths in Mid Staffordshire National Health Service Trust shows clearly that for many patients the most basic elements of care were neglected.

Calls for help to use the bathroom were ignored and patients were left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid. Patients were left unwashed, at times for up to a month. Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding.

Staff failed to make basic observations and pain relief was provided late or in some cases not at all. Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.

Such lack of care is not acceptable whether we are patients, carers or healthcare staff. How could it have happened? Nursing, medical and other staff do not join their professions to do harm. On the contrary. So what happened to their duty of care?

Please note that while the principles set out in this handbook apply to all parts of the United Kingdom, some details of the advice apply only to staff working in the NHS in England, because the provision of health care is quite separate and in important ways different in Scotland, Wales and Northern Ireland.

As the Secretary of State for Health stated in the *Daily Telegraph* (5 January 2013): “We must ensure that the compassion that led (nurses and care assistants) into the profession does not get ground out of them.” Most of the time NHS staff do tremendous work, not always appreciated, under immense pressure. This handbook is written to address those situations where staff are expected or instructed to behave in ways that compromise their duty of care and professional accountability with potential or act harm to patients or themselves.

We have written this handbook to encourage all staff, including managers, to assert their duty of care to patients and to thus help ensure that their employer complies with its duty of care to patients and to staff. Our practical advice is based on many years of advising and representing healthcare staff wishing to raise concerns about care quality and safety in hospitals and community health. It is also based on personal family experience.

Our aim is also to help patients and carers know what staff and their employers can be expected to do and so prevent any repetition of the circumstances that arose in Mid Staffordshire and have been reported from time to time elsewhere. Working together we can help everyone speak out and improve healthcare, and challenge those who seek to silence us. Our duty of care means taking responsibility - individually and collectively, professionally and personally.

Roger Kline & Shazia Khan, April 2013

This handbook went to press as the government published its initial response to the Francis Report. Nothing in the government response has a direct impact on the advice given here.

We comment on it further, and add updates to the advice given in this handbook, at our website:

www.thedutyofcare.org

““ The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care.

Morale at the Trust was low, and while many staff did their best in difficult circumstances, others showed a disturbing lack of compassion towards their patients.

Staff who spoke out felt ignored and there is strong evidence that many were deterred from doing so through fear and bullying.””

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009](#)

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1. Introduction

The Mid Staffordshire NHS Trust Public Inquiry Report is a direct challenge to government, NHS employers, health care staff and commissioners to transform the entire working and clinical environment to “make quality of care the central organising principle and overriding priority of the NHS” . (*Tom Kark QC, Para 288, [Closing statement](#) Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust.*)

There is now a wealth of research evidence that care outcomes and patient safety improve when an environment is created where staff are encouraged to question and challenge in the best interests of patients. As the Chief Nursing Officer for England put it: “Strong and effective leadership is essential at all levels in all organisations to set clear expectations to ... create an environment where the courage to speak out is welcomed and encouraged.” (*[Compassion in Practice Nursing, Midwifery and Care Staff. Our Vision and Strategy. NHS Commissioning Board. 2013.](#)*)

The [Mid Staffordshire Public Inquiry Report](#) insists that this must change so that staff concerns and patient complaints are welcomed as opportunities to improve services, rather than being seen as a threat or a problem.

The 2012 NHS national staff survey found that whilst the majority of NHS staff would know how to report any concerns they have about fraud, malpractice or wrongdoing, 28% would not feel safe raising these concerns and only just over half (55%) would feel confident that their organisation would address them.

http://nhsstaffsurveys.com/cms/uploads/NHS%20staff%20survey%202012_nationalbriefing_final.pdf

An indication of the difficulties staff feel in raising concerns is that though pressure on NHS staff has increased in 2012 there was a fall in the number of staff reporting errors, near misses and incidents when witnessing them.

1.1 Pressures on staff raising concerns

Health professionals are trained to exercise specific skills and provide care, support, advice and treatment to a safe and effective standard. Indeed, their job descriptions allow for disciplinary action if their work falls below the required standard or breaches their professional Code, whether as a doctor, dentist, nurse, midwife or in a profession allied to medicine.

At the same time there are immense pressures that undermine their duty of care. Those pressures may be through inadequate staffing, inappropriate skill mix, or because of a bullying environment where those who raise concerns are seen as “troublemakers”. The pressures may also be more indirect and subtle through the expectations or bullying from one’s peers, or a mistaken belief that unsafe practice might sometimes be justified or necessary, or a fear that one’s

The Francis Report published in February 2013 made a number of recommendations that, if implemented, could make it easier for staff to raise concerns and hold their employers to account.

For up-to-date advice, visit our [Duty of Care website](#).

job and career would be placed at risk should concerns be raised. Moreover, too often staff who do raise serious concerns which should be welcomed and legally protected instead meet apathy, resistance and even hostility from their employers.

This is not a new problem. A decade ago, at Bristol Royal Infirmary, a public inquiry report ([Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995 Command Paper: CM 5207](#)) found that some doctors colluded in poor practice that led to the deaths of a number of babies. One doctor, anaesthetist Steve Bolsin, did raise concerns but was ignored, and his “whistleblowing” led to his being ostracised by his fellow doctors and driven out of the UK to work in Australia.

Despite the supposed “learning of lessons” from the Inquiry that followed, and the subsequent emphasis on “clinical governance” alongside whistleblowing procedures, even worse scandals were to follow, most notably at Maidstone Hospital and Mid Staffordshire Hospital, where hundreds of patients died unnecessarily.

Equally appalling breaches of the duty of care of both the employer and staff have been reported in services for the elderly and people with disabilities. (See, for examples, the [Care Quality Commission evidence](#) on NHS elderly care and the Serious Case Review of the scandal at [Winterbourne View Hospital](#).)

This handbook focuses on one central concern of those reports. It offers advice and information to support the efforts of health professionals to uphold their duty of care when they come under pressure not to put patients’ interests first.

- Firstly, we explain what we mean by “the duty of care” owed by healthcare professionals and their employers.
- Secondly, we explain why and when that duty of care and professional accountability might conflict with instructions or expectations from your employer, directly or indirectly.
- Thirdly, we outline ways in which you can raise concerns, ask questions and challenge instructions or expectations that compromise your duty of care and professional accountability.
- Fourthly, we look at what a good employer should do to support staff and patients raising concerns in order to provide good, safe care.
- Finally we highlight some resources you may find helpful and draw your attention to [Public World’s Duty of Care website](#), which houses a range of online resources relevant to the issues in this handbook.

1.2 Who is this handbook for?

This handbook is intended mainly for registered or trainee professionals regulated by the [Professional Standards Authority for Health and Social Care](#). However, the broad principles set out here apply to all health care staff

“Organisations and individuals that patients, relatives and staff should have been able to rely on to raise the alarm failed to do so.

Instead, but for a campaign led by local relatives of those who died or were harmed, there would probably never have been a public inquiry at all.”

Julie Bailey. [From Ward to Whitehall](#). Cure the NHS, 2012

whether or not they are registered professionals, or are training to be registered professionals. They apply to everyone who works in health care whatever their employment status including:

- all NHS employees whether part time, temporary or full time
- all students in training when on work placement
- all agency staff or contractors providing health care services
- all those providing healthcare in private or voluntary sector settings

The framework of duties and responsibilities is also relevant to all healthcare managers whether or not they are clinical professionals. Three recent documents all make that clear:

- The [NHS Constitution](#)
- The [Standards for Members of NHS boards and CCG governing bodies in England](#)
- The [Speaking Up](#) charter

This handbook may also be useful to patients, relatives and carers as a guide to what professional staff can be expected to do and not do.

Throughout this handbook we refer to “patients” as shorthand for all those who use health services.

1.3 The importance of Mid Staffs and the Francis Reports

The recommendations of Robert Francis QC in his February 2013 report on Mid Staffordshire NHS Foundation Trust should strengthen the ability of staff to raise concerns.

The [Government's initial response to the Francis report](#) falls short of full endorsement of its recommendations, which in turn fell short of what was required. The report makes no recommendations on tackling bullying, for example, and avoids recommending statutory national staffing standards. But its recommendations, if implemented, will make it easier for staff to take the steps this handbook discusses.

However, the Government has ignored the recommendations on regulation of health care assistants. It has failed to be sufficiently specific on safe staffing levels and skill mix. It has fudged the issue of the responsibilities of senior managers both in respect of the duty of candour and regarding some form of professional regulation of general managers. It says nothing about the bullying culture so prevalent in parts of the NHS and which make a large minority of staff fearful or sceptical about raising concerns.

Whereas Robert Francis, the inquiry chairman, said that one of his top priorities was that the NHS constitution be rewritten, making it explicit that “patients are put first” and “everything done by the NHS should be informed by this ethos”, the redrafted constitution simply states that the health service will “aspire” to put patients first.

Nevertheless the Francis recommendations that have been accepted should make it easier for NHS staff to raise concerns, exercise their professional accountability and comply with their duty of care.

Box 1 - What the Francis Report recommends

If properly implemented, the Francis report's recommendation's will add to the contractual protection for staff who raise concerns and whistleblow through:

- Placing additional duties on employers, managers and staff to be open, honest, and transparent with patients and “enabling concerns and complaints to be raised freely without fear and questions asked to be answered”.
- Placing a duty on registered healthcare professionals to report it, as soon as is reasonably practicable, if they believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient.
- Employers having to ensure new statutory fundamental standards (which are part of the staff duty of care) are met.
- An improved requirement to raise incident alerts and for employers to respond to them.
- New requirements for senior staff to sign off commissioned services as being safe.
- Much improved rights to access information on safety “allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators”.
- New duties to ensure medical students can report concerns safely.
- A complete ban on gagging clauses that seek or appear to limit bona fide disclosure in relation to public interest issues of patient safety and care.
- A statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation.
- Both GMC and NMC having to launch proactive investigations rather than just respond to individual cases as referred.

For up-to-date advice and tools to support you in exercising your duty of care in difficult circumstances visit our [Duty of Care website](#).

2. What is the Duty of Care?

“All changes in service delivery, systems, equipment, staffing and resources must be measured against the impact on the standard of service provided.

Therefore, no change should be authorised or implemented without: – timely, and recorded, consultation with professional staff who are to deliver or whose service will be affected by the proposed change; – a proportionate, thorough and objective impact assessment, recorded in writing.

Where a change is authorised or implemented contrary to the expressed views of any professional staff or where any impact assessment highlights a risk of reduction in the standard of service, the managers or directors taking the decision must record their reasons for doing so in writing.”

Robert Francis QC.

The Mid Staffordshire NHS Foundation Trust Public Inquiry Report. (2013)

2.1 What the NHS must do

The NHS is required by statute and case law to:

- Provide a comprehensive and integrated health service.
- Be able to demonstrate that appropriate priorities have been chosen within the available resources.
- Ensure that patients and their carers have been appropriately consulted and informed about their care and treatment.
- Ensure that patients and their carers (and staff) have been treated in a manner that accords with the equality and human rights duties of the provider.
- Ensure, insofar as is reasonably practicable, that the environment within which staff are treated and cared for, and the equipment and substances used, are safe.
- Ensure that those providing care, treatment and advice are able to practice safely and carry out their duty of care (and that of the employer) to each patient.

Since the NHS does not have limitless resources, it is not possible for the NHS as a whole, or any individual NHS provider, to undertake every possible operation or provide care in all conceivable circumstances. Therefore, failure to do so would not necessarily be a breach of its duty of care.

“When I came to the department, I was more than surprised at the level of care that we regarded as being acceptable for an emergency department ...

The way in which we structured our care and in particular the battle fatigued attitude of the staff did not lead to – it wasn't conducive to – good quality care.

It was a case of getting through the day rather than how good can we be today?”

[Evidence to Mid Staffs public inquiry](#)

However, the courts have made clear that the healthcare provider must ensure that what *is* done is done safely and competently, that what cannot be done is made clear and that treatment and advice are provided with appropriate priority and urgency.

Failure to do so opens a healthcare provider to an allegation of breaching its duty of care, and this can provide staff with a useful benchmark for decisions about issues such as workloads and skills mix.

If harm results as a result of a breach of a duty of care then negligence may be alleged if:

- a duty of care must be owed between the person alleged to have been negligent and the person whose care was allegedly neglected
- that duty must have been breached; and
- harm must have been suffered as a result.

Employers must be able to demonstrate they have taken reasonable practicable step to ensure that the work environment in which staff practise is safe, such as by complying with minimum requirements of professional regulatory bodies and conducting regular risk assessments.

Though employers can be held vicariously liable for any breach of the duty of care owed to an individual, an employee can suffer loss of job, reputation and registration.

Figure 1 - The interconnected duties of care



2.2 What is the duty of care owed by staff to patients?

All health service staff have a duty of care to patients, colleagues and themselves. It provides the fundamental benchmark for their practice, against which employer instructions and expectations must be evaluated.

The courts have said that the standard of care that can be expected of any individual health care worker is the standard of a “reasonable man or woman”. For health professionals the courts have gone further, ruling that, in determining whether or not the duty of care was exercised, the standard of work must meet:

“The standard of the ordinary skilled person exercising and professing to have that specialist skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of the ordinary competent man exercising that particular art”.

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

That means that while a healthcare professional does not have to be the best nurse, midwife, scientist, technician, therapist, paramedic or doctor there is, they must practise at the standard of the “reasonably competent” practitioner. Such an ordinarily competent skilled healthcare professional is expected to:

- keep their knowledge and skills up to date
- provide a service of no less a quality than that to be expected, based on the skills, responsibilities, and range of activities within their particular trade or profession
- know what must be done to ensure that the service is provided safely
- keep accurate and contemporaneous records of their work
- not delegate work, or accept delegated work, unless it is clear that the person to whom the work is delegated is competent to carry out the work concerned in a safe and appropriately skilled manner
- protect confidential information except where the wider duty of care or the public interest might justify disclosure
- comply with statutory duties such as those around health and safety, equality and human rights
- draw to the attention of appropriate persons any concerns that they are not able to meet those standards.

These requirements apply whatever setting you work in, whatever the nature of your employment, and whether your employment is within the NHS, the private sector or the voluntary sector.

Across healthcare, a range of policies, protocols, and standards assist compliance with the duty of care and help achieve effective practice within each service and within each episode of care, treatment, support and advice. These vary between professions and between services, and have been developed by national professional bodies for individual professions, by the Department of Health or other national NHS bodies. For example, the Mid Staffordshire Inquiry highlighted the failure to meet the standards set out in the [Essence of Care](#)

Duty of care dilemma

You work as a health visitor. You are concerned that in two of the homes you visited recently, relatives have been racially abusive to you.

You have found this very distressing but when you reported it to your manager you received no helpful advice but were told you could change caseloads if you wanted to.

What should you do?

[benchmarks](#) which “help practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.”

Your employer’s framework of “clinical governance” should complement these specific policies, protocol and standards. You are expected to know and understand the policies, protocols and standards that apply to your particular profession and service. Any working arrangements or proposals for service delivery and available resources must ensure the staff duty of care can be met and take proper account of authoritative guidance in doing so.

2.3 Resources and the duty of care

If there are insufficient resources, or staff are not competent, or are not supervised appropriately, is that a defence for poor care?

It is not a defence if you might reasonably have been expected to know that the resources available were inadequate and potentially unsafe, or that staff (including yourself) were not competent or properly supervised.

If you knew, or might reasonably have been expected to know, that there were insufficient resources (appropriately competent staff or equipment for example) then you should have drawn your concerns about this to an appropriate person, normally your line manager in the first instance.

Nor is it any defence to argue that you were “instructed” to work unsafely or that everyone else thought it was safe or appropriate.

The resources allocated to a particular service are primarily set by negotiations between the organisation providing the service and the body commissioning and funding it.

The courts do not expect the NHS or individual agencies to be able to provide all the services that ideally might be provided at the time and place they might be needed.

The NHS and individual Trusts are however expected to prioritise the care, support, treatment and advice required and to ensure that the standards of care, treatment, support and advice remains at the level which should be provided by ordinarily competent professionals.

A failure by an NHS Trust to provide all the services required at the time and place where they are needed does not mean they have breached their duty of care since there are not limitless resources in the NHS or elsewhere. However, the obligation of an employer, manager and healthcare professional is to:

- ensure that what is actually done is done safely and appropriately
- make clear what cannot be done, or at least be done safely
- ensure the patient is treated with the appropriate urgency.

So, for example, if there are too few staff to undertake certain work or roles safely, then an employer might:

“ It should be recognised that where a standard of care acceptable to patients and the public, or sufficient professional staff to provide that care, cannot be delivered for financial or other reasons, the relevant service should be closed or suspended until such standard can be achieved. ”

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust 2005-2009](#)

- prioritise some work and stop other work
- bring in additional staff in sufficient numbers with the right skills to assist with the work
- change the way some work is done as long as the new arrangements meet the employer's and the staff duties of care.

What the employer cannot do is to spread the available resources so thinly that what is to be done cannot be done safely.

2.4 The duty of care of NHS employers to their staff and contracts of employment

The [first Francis inquiry](#) into what happened at Mid Staffs heard that conditions were so distressing to nursing staff on Ward 7 that, in January 2009, they wrote an anonymous letter to the Directorate Manager, which stated:

“At a recent meeting it was highlighted that our sickness rate was high and the submission of incident forms surpass others. We were asked why. We feel that it is a true reflection of the environment, the unrealistic demands and lack of resources. We all exhausted, mentally and physically.

We are fed up with tackling unmanageable workloads, going without breaks, not getting off on time, doing extras with no respite. The environment is neither safe for patients or staff. As registered nurses we are professionally obliged to raise our concerns. We feel compromised, bullied and disempowered.”

This group letter from nurses was ignored by Trust managers.

All employees have obligations and rights. Some of these are to be found in your written “statement of terms and conditions”, which should be received within two months of starting in a post and include details of job title, salary, holiday entitlement, and hours of work. It should also refer to other documents, such as the job description, the employer's disciplinary and grievance procedure, clinical protocols and standards, and works rules including health and safety arrangements. Together these documents constitute your written contract of employment, but some other “implied” duties, developed through jurisprudence, are assumed to be part of every contract of employment. These include an obligation on an *employer* to:

- employ a competent workforce
- provide a safe working environment
- take reasonable care for the safety of the employee including as set out in current health and safety legislation
- act in good faith towards the employee and not act in a way that undermines the trust and confidence of the employment relationship
- behave reasonably towards their employees
- not breach, or cause their employees to breach, any statutory duty they are owed or owe

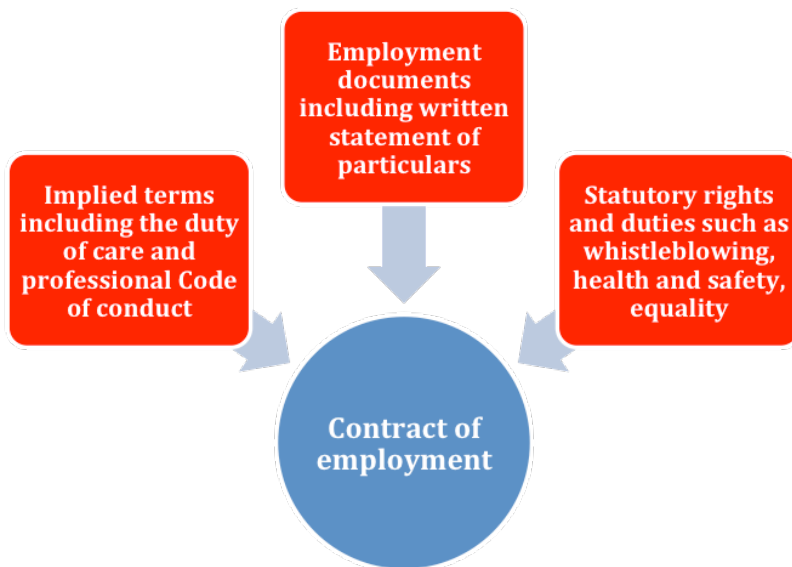
- deal promptly with grievances
- act in good faith and fidelity
- not act arbitrarily, capriciously or inequitably.

Employees, for their part, must:

- obey reasonable and lawful orders;
- take care of the employer's equipment;
- co-operate with their employer
- exercise skill and care in the performance of their work
- comply with any responsibilities arising from their status as a registered professional

Understanding these terms helps you know when and how you can and must question, challenge or refuse to carry out instructions or accept working conditions that are unsafe for your patients or for you.

Figure 2 - The duty of care in the contract of employment



Employers must have in place the resources, equipment, working environment, training, support, and systems such as clinical governance and specific protocols, to enable staff to comply with their duty of care, professional Code and relevant statutory duties. Statutory duties such as those referring to health and safety, equality and human rights, and to whistleblowing, are created by Acts of Parliament or by regulations that flow from them. Employees cannot be asked by an employer to give up their statutory rights or to fail to comply with their statutory duties, but it is not uncommon for employers to breach those rights and duties, knowingly or otherwise.

2.5 Health and safety

The [Management of Health and Safety at Work Regulations 1999](#) require employers to undertake risk assessments where health and safety may be compromised. The same principle of “risk assessment”, should be applied where patient safety is at risk. Section 2 of the Health and Safety at Work Act (HASAWA) 1974 requires employers to ensure, so far as is reasonably practicable:

- the provision and maintenance of plant and systems of work that are safe and without risks to health;
- arrangements for ensuring safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances;
- the provision of such information, instruction, training and supervision as is necessary to ensure (their) health and safety at work;
- as regards any place of work under the employer’s control, the maintenance of it in a condition that is safe and without risks to health;
- the provision and maintenance of a working environment that is safe, without risks to health.

Every employer should have in place detailed arrangements to comply with specific regulations and every workplace should have a system for reporting adverse clinical incidents affecting the health and safety of patients which should complement the health and safety arrangements for staff. Section 7. of the HASAWA 1974 requires every employee “to take reasonable care for the health and safety of himself and of others who may be affected by his acts or omissions at work”.

The health and safety of staff and the health and safety of patients are completely intertwined. As the [NHS Constitution](#) states, staff have a right to “have healthy and safe working conditions and an environment free from harassment, bullying or violence”. Patients have “the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.” The NHS also commits “to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice.”

2.6 Equality and human rights

The Equality Act 2010 requires employers to prevent discrimination and promote equality both in employment and in the provision of health services. Healthcare organisations must, in respect of both service provision and the care and treatment of staff and patients, monitor and analyse their actions

Duty of care dilemma

You are a consultant paediatrician. Both you and your colleague, a more senior consultant, agree that unless additional administrative and nursing support is provided, there is a real risk of serious safeguarding concerns.

You want to raise these concerns formally because informal discussions have not been fruitful. Your more senior colleague is reluctant to take the matter further.

What should you do?

and omissions to see what discrimination might be taking place and act to prevent it and promote equality.

[Research has shown](#) there is a direct link between discrimination against staff and the treatment of patients. For example, the greater the proportion of staff from a black or minority ethnic (BME) background who report they have experienced discrimination at work in the previous twelve months, the lower the levels of patient satisfaction. (*Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, Jeremy Dawson, Institute for Health Services Effectiveness, Aston Business School. 2010) .

Similarly, a bullying culture not only damages staff health but also undermines the teamwork, mutual respect and learning environment that is essential to good, safe, healthcare. If healthcare professionals see discrimination against patients or colleagues then their professional code (and healthcare ethics) will require them to report or challenge it.

The [Human Rights Act 1998](#) also provides for certain rights for patients and staff.

Employees are protected by statute against victimisation for exercising their rights under equality legislation, rights arising from undertaking trade union duties and activities, and rights arising from their role as health and safety representatives. Staff raising concerns about breaches of statutory duties or rights should be protected by the Public Interest Disclosure Act.

2.7 The significance of professional codes

Healthcare professions are regulated by statutory bodies that maintain a register, set standards and issue more detailed guidance on matters such as confidentiality, delegation of work, record keeping and raising concerns. These bodies include the Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC), the General Medical Council (GMC), the General Dentistry Council (GDC) and the General Osteopathic Council (GOC). Each of these professional bodies is in turn overseen by the Professional Standards Authority for Health and Social Care.

Failure to comply with the professional code can lead to removal from that professional register, which in turn bars you from being employed in the profession. As the Nursing and Midwifery Council (NMC) Code puts it: *“Failure to comply with this code may bring your fitness to practise into question and endanger your registration.”*

Many contracts of employment explicitly require compliance with the relevant code, and state that a breach of a statutory regulator’s code of conduct will be regarded as a serious disciplinary matter. But even if they do not the code forms an implied part of a registered professional’s contract of employment. However, only the relevant professional registration body, not your employer, is competent to decide whether a breach of the code has actually taken place.

Duty of care dilemma

You are a second tier manager for paediatric services. You are concerned that proposals to restructure services would significantly change the mix of registered and unregistered nursing staff and that this may mean unregistered staff being expected to work beyond their competence. What should you do?

If you were one of the registered nurses, what should you do?

If you were one of the healthcare assistants what should you do?

Every individual professional is personally responsible for compliance with the relevant code. For example, the NMC Code states: “As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.” A professional regulator’s code of conduct can reasonably be taken as a template against which employee practices may be judged. Instructions or expectations from an employer that deviate from this standard would need to be justified.

The Mid Staffordshire NHS Trust Inquiry has already prompted the General Medical Council to issue [new guidance for doctors](#). It is likely, following the Inquiry Report, that the Nursing and Midwifery Council and the Health and Care Professions Council will follow suit. They may also be more proactive in supporting those raising concerns and in holding managers to account.

Box 2 - Why the duty of care could mean refusing an instruction

State registered professionals who reasonably believe they have been instructed or expected to breach their own Code may conclude that this is likely to be a contractually unreasonable instruction which should be questioned, challenged and possibly refused.

In such circumstances, the practitioner’s obligations to their duty of care arising from their professional code takes precedence over their obligation to obey a conflicting instruction.

Loss of registration with a state registered regulator such as the GMC, NMC or HCPC is more serious than losing one’s employment since it prevents you practising that profession anywhere in the UK, not just with your current employer.

Not all staff are professionally regulated. General managers currently do not have a statutory register, although the Francis Report may lead to some form of regulation for Board members. The Francis Report also recommended that health care assistants should be regulated by the Nursing and Midwifery Council, although that recommendation has been rejected by the government.

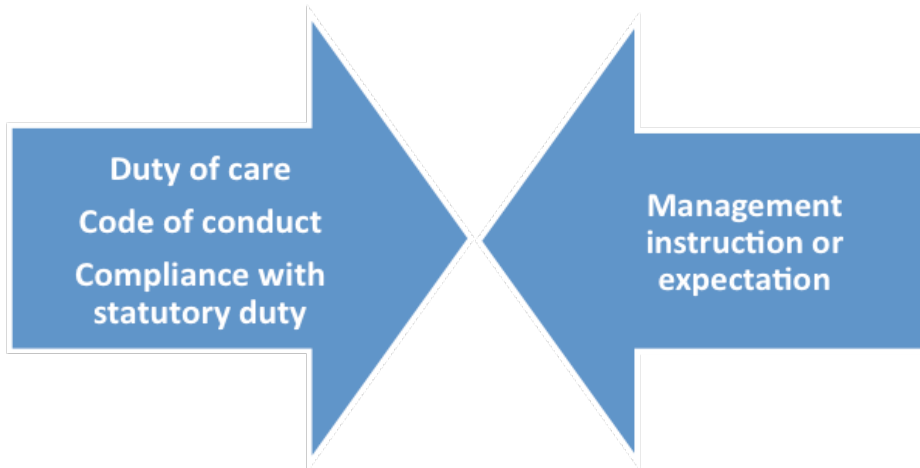
In addition to the statutory regulators there are non-statutory professional bodies whose roles include developing more detailed guidance on good practice, setting out expectations of standards of practice, and providing training and development for each individual profession.

Non-statutory bodies include the Royal College of Speech and Language Therapists, the Royal College of Midwives, the Institute of Biomedical Science and the Royal College of General Practitioners. Each has its own code, and failure to comply can mean removal from membership.

But as these are voluntary registers and have no statutory status, professionals may be able to continue to practise even after removal. For a speech and

language therapist, for example, removal from the HCPC Register prevents you practicing but removal from the RCSLT register does not.

Figure 3 - Tensions in the duty of care



If the care, treatment or advice provided (or its absence) falls below the standards arising from your duty of care, it is not a defence as a professional to argue that:

- **The shortcomings occurred because of your inexperience.** If you were too inexperienced to practise safely, you should have made that clear to your line manager or senior professional, who should in turn have made sure that the tasks or role in question were only delegated to, or undertaken by, competent persons who were appropriately supervised;
- **The shortcomings occurred because you complied with an instruction or expectation.** An instruction or expectation requiring you to work unsafely either by act or omission is one that should be recorded, questioned, challenged and possibly refused. Implicating another member of staff (or your manager) may bring their own acts or omissions into question but does not release you from your own responsibilities. If the acts or omissions were a collective team failure that does not excuse individuals. It is no defence to say “I was told to” or “everyone else was doing things unsafely.” In any case it is quite likely that the person whose instructions you claim to have followed may subsequently deny this was the case.
- **The shortcomings occurred because of inadequate resources.** Unless there is evidence that such concerns and their implications were identified and drawn to the attention of an appropriate manager, drawing attention to them retrospectively if they might reasonably have been highlighted prior to any breach of the duty of care may neither justify any subsequent breach nor mitigate an allegation that the duty of care was breached.

3. When your duty of care clashes with what you are asked to do

“All employees working in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.”

[NHS terms and conditions of service handbook](#). Amendment number 27 Pay Circular (AforC) 3/2012 Section 21: Right to raise concerns in the public interest (whistleblowing) (2012)

3.1 Personal accountability for the duty of care

You are personally accountable for your duty of care and your compliance with your professional Code. So what do you do if there is a conflict between what your employer expects you to do and what you believe is in the best interests of patients? Supposing management instructions or expectations place the health of colleagues, or themselves, or the wider public interest at risk?

Examples might include:

- workloads too heavy to be undertaken safely or which endanger staff health and safety
- tasks or roles inappropriately or unsafely delegated
- insufficient staffing to provide services safely
- unsafe equipment or working environment
- circumstances where staff are expected to discriminate against patients or staff, or to neglect the human rights of patients
- being expected or instructed to overlook concerns when you may be required by the staff duty of care, contract of employment, statutory duty or professional code of conduct to raise such concerns.

In all such circumstances any instruction or expectation that compromises the duty of care, compliance with a professional code, or compliance with a statutory duty must be questioned, challenged and if necessary refused because these obligations are components of the contract of employment, either explicitly or implicitly.

An employee cannot be asked to breach their own contract of employment, especially when there may be a risk of harm to others.

Questioning, challenging and if necessary refusing to follow such an instruction or expectations is not an ‘optional extra’. It is not something that can be left to ‘difficult’ members of staff or workplace union representatives. Taking advice before taking action is sensible, of course, although there isn’t always time. But

“The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care.”

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust 2005-2009](#)

you are personally accountable for your acts and omissions, so failure to act appropriately can lead to a charge of professional misconduct, a claim of negligence, or being charged with breaking a statutory requirement (as in health and safety or equality).

In the rest of this chapter we consider some specific concerns.

3.2 Workloads, staffing and skill mix

Workloads, staffing and skill mix are the most common issues that healthcare professionals raise concerns about. This is not surprising. Labour costs are the largest single cost in healthcare. Rising healthcare demand from a growing population and an increasing proportion of elderly patients has led to very high bed occupancy levels. Real terms NHS funding is falling. Resources are under immense pressure. Employers may seek to reduce staffing costs in particular by:

- Reducing the numbers of staff
- Diluting the skill mix so that more lower paid (and less skilled) staff are deployed – transferring doctors work to nurses or nurses' work to healthcare assistants, for examples
- Getting staff to work more intensively
- Reducing pay, terms and conditions including by outsourcing.

These do not necessarily have a negative impact on patient care and staff well-being, but they can easily have that effect and must be evaluated accordingly. If you have good reason to believe that workloads, skill mix, working environment or other working arrangements may not be safe then your duty of care requires you to raise your concerns and not stay silent. This could involve:

- Collating the evidence of the potential risk or harm and identifying specific concerns
- Cross-checking these concerns against relevant trust or national policies and protocols
- Discussing these issues with colleagues
- Thinking about how to raise concerns and ensuring they are recorded
- Resolving issues with management when possible and, if that doesn't happen, involving your union or professional body
- Ensuring that a clinical risk analysis and a staff health and safety risk analysis are undertaken if there are significant changes to workloads, staffing levels, skill mix or other working arrangements.

There is a [growing body of evidence](#) demonstrating the relationship between staffing levels and ratios with patient care and safety. Individual professions and service have a growing body of recommended staffing ratios and skill mix. Using these is essential and they are available from the web sites of national professional bodies. For example, the NHS Commission Board's [Compassion in](#)

“ I heard much evidence suggesting that members of staff lived in an atmosphere of fear of adverse repercussions in relation to a variety of events.

Part of this fear was promoted by the managerial styles of some senior managers.”

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust 2005-2009](#)

[Practice](#) sets out a requirement for evidence-based methods of determining staffing levels and skills mix.

The Royal College of Nursing has also produced [Guidance on safe nurse staffing levels in the UK](#), an excellent compilation of the evidence that staffing levels and skill mix ratios make a very significant difference to nursing outcomes. Medical colleges and other professional bodies give specific guidance on particular services and these would normally be applied by individual employers. Moreover the Mid Staffordshire Public Inquiry heard that there is substantial evidence of a connection between medical staffing levels and healthcare outcomes as summarised in the [closing submission](#).

There is [similar evidence](#) that the ratio of skilled to less skilled staff is an important determinant of outcomes for patients. In considering staffing levels and skill mix it is essential that guidance such as the Department of Health's [Essence of Care 2010](#) is used, while professional bodies have issued their own guidance.

For example, the [Nursing and Midwifery Council guidance](#) on skill mix states:

- You must establish that anyone you delegate to is able to carry out your instructions.
- You must confirm that the outcome of any delegated task meets required standards.
- You must make sure that everyone you are responsible for is properly supervised.

3.3 Staff as advocates for patients, relatives and carers

One of the most striking aspects of the failures at Mid Staffs Hospital was the way in which those patients, relatives and carers who did raise concerns or made complaints were seen as a 'problem'. In fact, if care falls below the standards patients are entitled to expect, then complaints are one way in organisations and staff should learn from that experience. The guide to the [Local Authority Social Services and NHS Complaints Regulations 2009](#) state:

“When someone is unhappy with your service, it is important to let them know their rights when it comes to making a complaint. In the NHS, these rights are articulated by the NHS Constitution. “

Service users and carers in England should know that these Regulations state that:

- Verbal complaints not resolved within one working day will be required to be put in writing by the responding body and forwarded to the complainant (section 13);
- Complaints made verbally but not successfully resolved within one working day, and those made in writing or electronically, such as by email, will need to be acknowledged within three working days, which can be done either verbally or in writing (section 13):

Duty of care dilemma

You are a nurse on a surgical ward. You are asked by a relative why a medication mistake that was noticed yesterday has not been put in the patient's records.

You then realise that the most recent records do not include a second 'near miss' that a colleague mentioned to you. The patient has not been told of that 'near miss'.

What should you do?

- In the acknowledgement the responding organisation must offer the complainant the opportunity for a discussion at a mutually convenient time (section 13);
- The purpose of the discussion is to determine how the complaint is to be handled and the timeframe in which to seek resolution (section 13);
- The responding body is required to investigate the complaint in a manner appropriate to “resolve it speedily and efficiently and, during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation” (section 14);
- The complainant must be sent a written response signed by the “responsible person”, which describes how the complaint has been considered, what conclusions have been reached and what actions, if any, have or will be taken as a result. (The “responsible person” in the NHS is the chief executive or someone deputed by him);
- The normal time limit whereby people can raise their complaint is extended to 12 months and can be longer depending on the circumstances (section 12).

3.4 What must the healthcare professional do?

It is not possible to learn from mistakes and poor practices if they are denied or covered up. There are many pressures which lead professionals to stay silent or collude in poor practice. The power of the employer is very immediate and the risk of disapproval from colleagues or even losing one’s job is very real. But healthcare is (or should be) underpinned by ethics as well as the contract of employment.

The General Medical Council states that:

“Concerns about patient safety can come from a number of sources, such as patients’ complaints, colleagues’ concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority.”

[Raising and acting on concerns about patient safety](#), General Medical Council, 2012

The [NMC Code states](#) (paras 4 and 52- 55):

- You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.
- You must give a constructive and honest response to anyone who complains about the care they have received.

Duty of care dilemma

You are a laboratory scientist. You are concerned that equipment you are required to use is of poor standard, breaks down, and appears to give inaccurate readings.

You and a number of colleagues share your concerns with your manager. She says new equipment to replace this has been ordered but won’t arrive for five months due to budgetary constraints.

What should you and your colleagues do?

- You must not allow someone's complaint to prejudice the care you provide for them.
- You must act immediately to put matters right if someone in your care has suffered harm for any reason.
- You must explain fully and promptly to the person affected what has happened and the likely effects.

Your employer will have a local procedure on how to assist those patients who wish to raise concerns or make complaints. It should be on your Intranet. Good employers welcome those who raise concerns or make complaints as an opportunity to improve services. So, if you are asked by a patient, their relative or carer about how to raise concerns or make complaints, health care professionals should check the local procedure, bear in mind what your Code of conduct requires you to do, and what the NHS Constitution says.

You should then:

- Advise patients, relatives and carers how to raise individual concerns and complaints – whether informally or more formally;
- Alert your manager to your action and if you share the patient's concern, make clear to your manager that you do so, and why, in writing.

Complaints help an organisation learn. Healthcare providers benefit by learning from complaints and analysing adverse incidents and mistakes, especially if there is a pattern to them. NHS complaints procedures should complement NHS clinical governance and the National Patient Safety Organisation adverse incident reporting procedures.

If a patient's complaints are not resolved locally then patients can [complain to the CQC](#) about the process and to the [Parliamentary Health Ombudsman](#) about the issues themselves. .

If you have good reason to believe that the concerns or complaints of patients, carers or relatives may not be acted upon or responded to appropriately then you must raise your concerns and not stay silent.

In England a new organisation, [Healthwatch](#) has been established to assist patients, relatives and carers to make complaints and co-ordinate local scrutiny and advocacy. The Francis Report recommended its role be strengthened as there were serious concerns about its remit and funding.

3.5 Unsafe for patients, unsafe for staff?

Staff health and safety and patient health and safety are inextricably linked. All hospitals and community services have health and safety systems in place to ensure, so far as is reasonably practicable, the health and safety of both patients and staff.

Risk assessment underpinned by systems of monitoring and alerts should be at the heart of such systems. The [Management of Health and Safety at Work Regulations 1999](#) require employers to undertake risk assessments where

Duty of care dilemma

A colleague in a very overworked radiography department is regularly rude to patients and carers.

You approached him to ask him to reflect and stop. He says he is far too busy to do so.

What should you do?

health and safety may be compromised. The same principle applies when patient safety may be at risk. It is essential that alerts are monitored and lessons are drawn from all incidents, errors, mistakes and near misses that are notified.

Health and safety legislation requires your employer to comply with, and be proactive about, their health and safety duties to staff and patients. These include addressing issues such as stress at work (and its causes) and bullying at work (and its causes), both of which can directly impact on patient care as well as staff health. If employers ignore their duties there is plenty of advice available on steps to take, notably on the [TUC's website](#).

In every workplace health and safety representatives have statutory protection to inspect workplaces and be consulted on hazards at work such as stress, needle stick injuries, and manual handling “accidents” (which alone cost the NHS some £400 million each year with permanent injury and lost careers for staff). Health and safety representatives have legal rights to inspect, access information, and be consulted. Managers have crucial responsibilities for the health and safety of both patients and staff and should receive appropriate training and have easy access to good advice.

3.6 When does poor service breach the duty of care?

Kindness, respect, compassion and careful communication make a real contribution to patient care and experience. So do personal hygiene for patients, adequate food and drink, appropriate continence care, and effective management of conditions such as pain and pressure ulcers, all areas of care that were sharply criticised in Mid Staffordshire. The sort of benchmarks set out in the [Essence of Care 2010](#), for example, help staff know what good practice requires.

There will be many circumstances where, although the standard of care does not risk immediate and obvious harm to the patient, it falls below other authoritative standards or good practice. It is not good enough for patients to receive appropriate treatment and medication but not be shown respect or compassion, not least as this may well affect health outcomes.

“Many of the accounts of the patient experience at the Trust described clearly impacted on patients’ dignity. There were notable causes for concern which included:

- incontinent patients left in degrading conditions;
- patients left inadequately dressed in full view of passers-by;
- patients moved and handled in unsympathetic and unskilled ways, causing pain and distress;
- failures to refer to patients by name, or by their preferred name; and
- rudeness or hostility.” [First Francis Inquiry](#)

Duty of care dilemma

You are a Senior House Officer. You have become increasingly concerned at hygiene on the wards you work on, particularly the standard of work of the cleaning contractors.

When you raise it with your consultant you are told he has complained before and nothing was done and he is not willing to waste his time complaining again.

What should you do?

The First Mid Staffordshire Inquiry report gives many examples of such poor care, and professional codes are quite clear about the importance of such aspects of care. For example, [Good Medical Practice: Duties of a Doctor](#) says doctors must respect the dignity of patients and treat them “politely and considerately”.

There will often be a fine line between care that lacks compassion, kindness, respect and attention to such matters as careful communication and personal hygiene, on the one hand, and care that is dangerous on the other. A working environment where such standards are not upheld must be questioned and challenged, not least because such failures potentially affect care quality and outcomes.

3.7 What if my colleague’s work is poor or unsafe?

If you are concerned about the practice of a colleague, your first loyalty is to the service user. Professional codes are clear on this. How you discuss the issue and what you do if informal discussion is not effective may vary.

A [‘just’ workplace culture](#) distinguishes between:

- **Human error** - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake;
- **At-risk behaviour** – behavioural choice that increases risk where risk is not recognised or is mistakenly believed to be justified; and
- **Reckless behaviour** - behavioural choice to consciously disregard a substantial and unjustifiable risk.

If possible you should speak directly and informally to the colleague whose practice you are concerned about. You should initially seek to encourage them to reflect on their poor practice, and suggest they draw it to the attention of their line manager themselves, before someone else does it for them or before there is an avoidable adverse incident.

If the person whose practice you are concerned about believes that workloads, inappropriate delegation or other concerns are, at least in part, the cause of the practice issues, then they must raise those themselves.

If an informal discussion does not have the desired effect then you should report it to your own manager. If you are aware of underlying causes, then you should mention those as well, especially as that may discourage attempts to ‘blame’ the practitioner rather than considering first how his or her practice might improve.

You may also want to alert your trade union representative, especially if you are concerned that the cause of the poor practice is excessive workload, inappropriate delegation, unsupportive colleagues, a bullying manager or stress in which it is likely that these issues may affect other staff.

If the practice causing concern might constitute a serious risk, then disciplinary action might result. The interests of patients and service users come first but

“You have the right to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated.

The NHS commits, when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.”

[NHS Constitution](#)

the employer also has a duty of care to the member of staff. (It should not be assumed that suspension is the appropriate first step - see our [advice note](#) at www.thedutyofcare.org).

Unless the practice you are concerned about comes into the 'reckless' category, the emphasis should be on providing support and on understanding the root cause of the issues leading to poor practice. Unfortunately, disciplinary action is often a 'knee jerk' reaction to poor practice, especially where the alternative is a more profound examination of any underlying systemic organisational problems behind poor practice.

When disciplinary action is considered, there should be a thorough investigation prior to any proceedings commencing. The person facing allegations must have the opportunity to examine the allegations, see the evidence, be accompanied at all meetings where they are discussed, and be properly represented at any hearing.

Since [staff from minority ethnic groups are disproportionately involved in bullying and harassment cases](#), and are over-represented in disciplinary and grievance procedures, it is important that discrimination, intended or otherwise, is prevented.

3.8 Patients, carers and relatives rights to be consulted

The role of healthcare professionals as advocates is not confined to support and advice for individual complaints. Service users and their representative organisations are entitled to be consulted on many aspects of changes to services. Case law (e.g. Haringey Consortium of Disabled People and Carers Association v Haringey) has established that consultation at the formative stage of a proposal must:

- Provide enough information to enable those consulted to form a well-informed view;
- Allow enough time for a response;
- Show that the decision-maker has given conscientious consideration to the response;
- Take account of equality duties.

Section 2a of the NHS Constitution also insists:

“You (patients) have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”

NHS staff who draw the attention of patients or carers to such processes, or take part in them themselves, will need to make it clear that they are not speaking on behalf of their employer when doing so.

For up-to-date advice and tools to support you in exercising your duty of care in difficult circumstances visit our Duty of Care [website](#).

4. How to raise concerns

4.1 The challenge of raising concerns

Raising concerns can be very challenging. An individual healthcare professional or manager may have concerns which are not shared by all colleagues, or colleagues might be fearful of raising them. The pressures on a manager wishing to raise concerns may be even greater than for staff. Students, trainees and contractors might not be clear on their rights and duties.

However, if you believe you have genuine concerns then your duty of care requires you to raise them even if this makes you unpopular at the time. Taking the easy course may avoid short term pressures but is not appropriate or defensible if it harms patients, colleagues or yourself.

Moreover if you do not raise such concerns then you may well be held accountable should harm result. Simply because colleagues are unwilling or afraid to raise concerns does not mean you shouldn't.

Each individual health care worker has a responsibility to ensure legal duties are adhered to and registered staff must adhere to the Code of professional conduct. However, wherever possible staff should raise concerns collectively, drawing on external advice from their trade union or professional body.

Typical circumstances in which staff may need to question or challenge instructions or expectations in order to comply with their duty of care and professional accountability include:

- when there is a need to respond to an unexpected event or emergency
- when a continuing hazard or poor practice needs to be remedied and a long term solution is needed
- when new services or new ways of delivering existing services are being considered
- when services are being cut or reduced

Serious or imminent danger

Where there is an emergency or serious and imminent danger to themselves or patients, employees can rely on the statutory protection offered to health and safety activities ([Regulation 8, The Management of Health and Safety at Work Regulations, 1999](#)).

Health and safety representatives have statutory protection in the workplace but it is essential to take advice before raising your concern, and especially before disobeying an instruction or taking other action.

“Incident reporting systems were criticised by many staff, in particular because of the lack of feedback and because reports attributing incidents to staffing issues were perceived to be discouraged. These factors led some staff to be reluctant to file incident reports.”

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust 2005-2009](#)

Continuing risk or poor practice

If there is a continuing hazard or poor practice that needs to be remedied then it may be best, initially, to try to raise the concerns with your immediate manager, either in supervision or informally. Alternatively you may file an incident report using your employer's local procedure. However you raise your concern, you must ensure there is a written record of your having raised the concern – either explaining why you need a meeting or confirming the concern after the meeting. Unless a concern is recorded in writing it may later be denied that it was raised, or there may be ambiguity about the precise nature of the concern, or when and with whom it was raised. Sometimes, simply placing your concerns on the record will be sufficient to produce the desired result.

Changes to services

The risks may be in the future. Where new services or new ways of delivering existing services are being considered, or where services are being cut or reduced, then it is essential that staff delivering the service are fully consulted and that risk assessments -- both a clinical and health and safety -- are undertaken.

In all these cases, where informal or low key ways of raising concerns are not effective then you can raise the matter more formally, if necessary as a grievance. However, if the matter is urgent or there is a real risk of harm then you may need to make use of the employers [whistleblowing](#) procedure.

You are strongly advised to use the internal procedures initially, and to start with your own manager. We also strongly advise that you take advice from your union or professional body before drafting any letters and certainly before using the whistleblowing procedure. Above all, it is essential that you maintain a paper trail setting out very clearly what your concerns are and what you want to achieve.

Whichever course is appropriate, individual members of staff, and, where possible, the staff group collectively, must ensure they act in a way that

- highlights the precise problems rather than making general statements,
- demonstrates the seriousness of the situation, and
- gives the NHS employer no option but to respond quickly and appropriately or run the risk of successful challenge and possible public embarrassment.

You might find the following checklist helpful -- and there is a lot more detail in our advice notes at www.thedutyofcare.

“All employees working in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest.”

[NHS Terms and Conditions of Service Handbook Section 21](#)

Box 3 - Raising concerns checklist

1. *Are you clear what you are concerned about and why?* What evidence do you have and can you get more?
2. *Does this issue affect just you or can you raise your concerns collectively?* If no one else wants to raise your concerns, you should still raise them.
3. *Have you placed your concerns “on the record”?* Even if you raised them verbally it is essential that there is an audit trail. Such evidence is essential to protect patients (and yourself).
4. *Have you set out what you want to achieve?* Before you raise your concern, be as clear as you can what you want to achieve.
5. *Is it possible to work together with your employer to address your concerns?* It may not be, but if it is respond positively
6. *Check your employer’s procedures for raising and escalating concerns.*
7. *Set out in a single statement what your concerns are, the evidence in support, what you want done, when and why.*
8. *If you are offered a meeting don’t just turn up for the meeting, prepare for it.*
9. *Make sure there is a professional, accountable, relationship between those raising concerns and anyone accompanying or representing you such as a trade union representative.*
10. *Hope for the best but prepare for the worst.* Raising concerns is rarely straightforward and can meet with denial, resistance or worse.

4.2 How should healthcare professionals raise concerns?

Each individual health professional has a personal responsibility to ensure compliance with their duty of care to patients, to colleagues, and to themselves. They must comply with their professional code of conduct. They must comply with statutory duties notably on health and safety, human rights and equality. It is quite likely that other staff share the concerns about the instruction or expectation being challenged, and, if so, then a collective response may be possible and would be preferable.

However, where a collective response is not possible there are essential steps each member of staff should take. For example, [Good Medical Practice: Duties of a doctor](#) requires individual GMC registered doctors to “act without delay if you have good reason to believe that you or a colleague may be putting patients at risk”.

The NMC Code similarly requires individual registrants: “Where you cannot remedy circumstances in the environment of care, you must report them to a

Duty of care dilemma

You have worked as an agency nurse for nine months in the same hospital.

After unsuccessfully trying to raise concerns with your team leader for several weeks that elderly members of staff were being discharged from hospital too quickly and without adequate discharge plans, you put your concerns in writing.

You are then called in, told that there have been complaints about your timekeeping and that your contract is being ended with one week’s notice.

What should or can you do?

senior person with sufficient authority to manage them....This must be supported by a written record.”

It is important to note that taking such action is not an option and that the report must be in writing. Detailed advice on how best to do that can be found [here](#). Failure to do so can have dire consequences not only for patients but also to you: you might be reported to your professional regulatory body, which is becoming more common after the Mid Staffs debacle.

It is helpful to distinguish between matters that can be raised informally with local managers and those matters that require a more formal approach. Where possible, concerns should be raised informally, but with a written record, as long as this does not give an opportunity for unreasonable delays in tackling the concerns raised. Do not make a general statement such as “it is unsafe” without explaining why.

Your own employer will also have an [incident report system](#) you should follow. In good employers, depending on the urgency of the situation, raising concerns informally, albeit with a written record of having done so, should be sufficient. If effective [clinical supervision](#) is in place, then that should also be an effective way of raising concerns.

It may well be that your manager shares the concerns you raise and actively seeks a written record that they can draw to the attention of their manager. On the other hand, it may be that the manager seeks to dissuade you from pursuing concerns. In that case, take advice from a more senior colleague, your professional body, your union and/or a trusted colleague, and put your concerns in writing to management either individually or collectively. Explain your concerns simply and clearly and where possible support them with evidence and references. (For pro forma letters go [here](#).) Insist that any instruction to undertake duties believed to be unsafe is put in writing by management.

Bear in mind that even where an employer says that they will take responsibility for any harm that may result from your acts or omissions as a result of your concerns, this is meaningless. You (and they) cannot delegate your duty of care in this way.

4.3 What if I am a manager?

There is a great deal of evidence from the UK and elsewhere about what sort of working environment, management culture and clinical systems best encourage good and safe clinical practice. Given their core accountability in respect of the quality of care, NHS employers from Board level downwards are expected to provide a working environment that ensures the allocation of resources, management culture and clinical systems promote good quality care and are safe. That must inevitably include a culture where speaking out – whether by patients or staff – is welcomed, not avoided or resisted.

“Safe and consistent care cannot be delivered unless change is properly planned and risk assessed with proper management of the staff whose duty it is to deliver that care.

Finance, in the sense of the resource made available to the Trust, must always be the servant of the trust’s purpose – the delivery of good and safe care – and not the master which dictates the standard of delivery, however poor.”

[Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust 2005-2009](#)

Many healthcare professional managers will have precisely the same sort of concerns (and duties) as their staff, but there is greater pressure on managers to “toe the line”.

A manager who is also a healthcare professional is required to continue to comply with their own code of conduct for as long as they are on the professional register, whether they are practising or not. Both the GMC and the NMC provide specific guidance for managers who are registered professionals. The [GMC states](#) *Raising and acting on concerns about patient safety (2012)*:

- If you are responsible for clinical governance or have wider management responsibilities in your organisation, you have a duty to help people report their concerns and to enable people to act on concerns that are raised with them.
- If you have a management role or responsibility, you must make sure that:
 - a. there are systems and policies in place to allow concerns to be raised and for incidents, concerns and complaints to be investigated promptly and fully;
 - b. you do not try to prevent employees or former employees raising concerns about patient safety – for example, you must not propose or condone contracts or agreements that seek to restrict or remove the contractor’s freedom to disclose information relevant to their concerns;
 - c. clinical staff understand their duty to be open and honest about incidents or complaints with both patients and managers;
 - d. all other staff are encouraged to raise concerns they may have about the safety of patients, including any risks that may be posed by colleagues or teams;
 - e. staff who raise a concern are protected from unfair criticism or action, including any detriment or dismissal.

In [Raising and Escalating Concerns \(NMC 2010\)](#), the NMC placed a similar duty on nurse and midwife managers to promote “an open and accountable environment in which staff are encouraged to raise concerns about the safety of people in their care”, which “will increase the identification and prevention of problems, and will be a positive step towards safeguarding the public”.

Other management standards set by your employer will be contained in job descriptions and in the local arrangements for clinical governance. In his closing remarks to the Mid Staffordshire Public Inquiry, counsel to the Inquiry, Tom Kark QC emphasised the crucial responsibilities of nurse, midwife and medical managers.

Senior managers now have specific standards they are expected to comply with and set out in [Standards for members of NHS boards and governing](#)

Duty of care dilemma

You are the Director of Nursing. You have received a long document setting out concerns about bullying on two wards which the complaint says is affecting standards of care.

A CQC inspection is imminent and you probably would prefer to get that “out of the way” and then respond to the complaint.

What should you do?

[bodies in England](#) and these are likely to be made more rigorous after the Francis Report.

Standards for NHS Board members include:

- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such identified concerns;
- Ensuring that effective complaints and whistleblowing procedures are in place and in use;
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct;
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.

If staff are raising concerns then managers should sit down with those staff and ask whose care or safety it is believed may be at risk and why. If incident alerts have been submitted managers should ask for the evidence that supports the concerns being raised. If the concerns are raised by a group of staff then the discussion should be with that group or its representatives. The discussion should avoid defensiveness. It is in the manager's best interest (and the employer's) that concerns are raised and addressed.

The manager should then cross check those concerns against the policies, procedures and standards of the employer which in turn ought to be based on best practice set by professional bodies or other authoritative bodies, or by regulation and guidance.

The manager should take advice from other suitably qualified and experienced professionals. This is particularly important if the manager is not qualified in the profession raising the concerns or is not up to date in the service or procedure in question.

Managers themselves are expected to use a range of processes and skills to determine whether circumstances might be unsafe. Clinical governance should have put in place monitoring and learning systems whereby staff and patients are encouraged to raise concerns. The reporting system for adverse incidents should help identify patient safety risks. So should clinical governance notably good supervision.

Any response may well involve further discussion but should be timely and in writing. If the concerns are well founded it should not be necessary for staff to trigger the grievance procedure (or even the whistleblowing procedure).

Nor should it be necessary for patients (or carers) raising concerns to take them through the formal complaints procedure if a timely and reliable response can be given. However, managers must note the timescales and

Duty of care dilemma

You are a second tier manager leading a district nursing services.

You are concerned that proposals to restructure services significantly change the mix of qualified district nurses and district nurse assistants and that this may mean some staff being expected to work beyond their competence.

What should you do?

If you were one of the registered nurses, what should you do?

If you were one of the healthcare assistants what should you do?

requirements of the complaints procedures, which are based on statutory regulations.

The employer's (and manager's) responsibility is not to ensure that all services and roles currently undertaken must continue whatever the impact on staff or patients. On the contrary, the manager must:

- ensure that whatever work is undertaken can be done safely and to the standard expected of the ordinarily competent professional;
- ensure that any delegated work can be safely undertaken;
- ensure that staff who are required to assess needs are not put in a position where they cannot do so adequately, or where their practice may not be up to date, or they cannot maintain contemporaneous records.

What specific steps this requires will depend on the clinical priorities set by the employer, the available resources and equipment, and the relevant clinical policies, standards and protocols. This might mean services, roles, and procedures being changed, but could also involve deciding certain tasks or roles will not be done until they can be done safely, or changing priorities for staff. It is likely to involve some form of risk assessment, whether the risk is to patients or to staff.

The manager will need to manage staff such that the professional standards of those staff does not fall below the standard of the ordinarily competent health professional or breach their professional Code. If this is not possible then s/he must inform his/her own manager in writing that a potentially unsafe situation exists, explain why, and seek advice. S/he will then need to ensure that the issues raised receive an early and appropriate response, which should be confirmed in writing.

It may then be necessary to place those concerns on the employer's Risk Register following your employer's procedure.

Staff and managers should be aware of the role of [National Patient Safety Agency](#), which provides guidance on patient safety issues.

4.4 Guidance for healthcare students

Among the most worrying pieces of evidence offered to the second Francis Inquiry came from a witness who said:

“The failure of students to complain suggests that they were being socialised to accept a culture of indifference where poor standards were the norm.”

That is worrying because health care profession students should be learning quite the opposite -- that they have a duty of care that provides the basis of the ethics of their chosen vocation. In the case of medical students, [the GMC requires](#):

Duty of care dilemma

You are a student healthcare professional. You are asked to undertake work you don't believe you should carry out unsupervised, but due to staff shortages you are asked to “please get on with it”.

What should you do?

You should report any issues or concerns about the quality of your clinical attachment or student assistantship to your medical school.

Remember that the duties of a doctor registered with the GMC state that you should act without delay if you have good reason to believe that you or a colleague may be putting patients at risk. If you are exposed to situations during your clinical attachment or student assistantship where patients are being put at risk, you should report this to your medical school immediately.

Similarly, the NMC [Guidance on Raising and Escalating Concerns](#) requires (Section 7) that students:

7.1 inform your mentor, tutor or lecturer immediately if you believe that you, a colleague or anyone else may be putting someone at risk of harm

7.2 seek help immediately from an appropriately qualified professional if someone for whom you are providing care has suffered harm for any reason

7.3 seek help from your mentor, tutor or lecturer if people indicate that they are unhappy about their care or treatment.

The Guidance adds (Section 8):

We recognise that it might not be easy for you to raise a concern; you may be unsure what to do or the process may seem quite daunting. If you want some advice at any stage, we recommend that you talk it through with your university tutor or lecturer, your mentor, another registered nurse or midwife, or the supervisor of midwives in your practice area. You can also speak to your professional body, trade union or PCaW (Public Concern at Work) who can offer you valuable confidential advice and support. Where this document refers to seeking advice, all of these possible options apply to you.

The Health and Care Professions Council (HCPC) [guidance for students](#), which needs to be strengthened in the light of the Mid Staffs scandal and the Francis report, states:

You should always act in the best interests of your service users. ... If you are worried about a situation which might put someone at risk, you should speak to a member of the placement team or your education provider.

A student's academic institution also has a responsibility to ensure students understand their responsibilities and to appropriately support students raising concerns. Students may need to check with their medical school or academic department how best to do this as each institution will have its own policy.

Duty of care dilemma

You are a group of speech and language therapists.

You have learnt unofficially that a 30% cut in staffing, partly made by not filling vacant posts, is planned. Staff are concerned that they simply will not be able to work safely.

What might you do?

4.5 What if I am alone in raising concerns?

Raising concerns at work is never more difficult than if you are the only person in your laboratory, ward, health centre or department doing so. Other staff may share the same concerns but are afraid to raise them. Their failure to comply with their professional accountability does not reduce your personal responsibility.

All professional Codes make it clear that as a professional, you are **personally** accountable for actions and omissions in your practice, and **must** always be able to justify your decisions. Similarly, your duty of care is a personal one.

But it can have very difficult consequences, as [Helene Donnelly](#), who had the courage to raise concerns at Mid Staffordshire, found out. Similarly, [Jennie Fecitt](#) and colleagues at NHS Manchester who blew the whistle found out that work can be a very difficult place if colleagues turn against you because you raised concerns.

Robert Francis, QC, acknowledged the need to protect whistleblowers when launching the report of his second Mid Staffs inquiry:

“I have called for a statutory duty of candour that trusts tell the truth to regulators and that there should be criminal sanctions if there’s wilful obstruction of anyone performing their duties. That is about as rigorous a protection of whistleblowers as you can imagine, and that’s what I intended.” [Robert Francis QC 14th February 2013](#)

Other staff involved in high profile cases, such as Dr Kim Holt, Dr David Drew and former Trust chief executive Gary Walker, raised concerns and despite the immense pressures they have been subjected to since, were right to do so. If acts or omissions are a collective team failure that does not excuse individuals within that team. It is no defence to say “I was told to” or “everyone else was doing things unsafely”. In any case, the person whose instructions you have followed may subsequently deny having given those instructions.

4.6 Raising concerns collectively

Although the duty of care is a personal responsibility, however, a collective response may be a much more powerful way of ensuring appropriate action is taken in a timely manner and without adverse consequences for the staff or patients concerned.

To develop a collective response, the following checklist might be helpful, and you can find tools such as model letters and guidelines about drafting briefings on our [Duty of Care website](#):

“There is a real fear among junior staff (particularly among junior doctors and nurses) that to comment on colleagues, particularly consultants, is to endanger their future work prospects.

The junior needs a reference and a recommendation; nurses want to keep their jobs.

This is a powerful motive for keeping quiet.”

[Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995](#)

Box 4 - Checklist for raising concerns collectively

Be clear about your concerns and clarify what your employer's response is to them. Seek that clarification in writing.

Set out the issues clearly for colleagues and your employer. Be clear what outcomes staff are seeking. Avoid hypothesis and exaggeration.

Gauge staff support either informally in a department, ward or health centre, or more formally through a meeting. It may be helpful to do a short staff survey.

Determine the level of urgency If there is immediate risk to patients or staff, for example, the timescale and speed of escalation should reflect that.

Develop a strategy Your employer might support you and then you can work in partnership, but if not a more formal approach will be necessary.

Don't forget to communicate with all relevant staff and with your union, professional body, managers and others as necessary.

In preparing a response you should remember there can be a lot of research and gathering of information involved. Important sources can include minutes of Trust committees, workforce reports and so on, many of which are public, and Trust policies and protocols. The policies and protocols of national and professional bodies are also relevant, as they set out the framework of clinical practice and employment standards that should be followed.

The Freedom of Information Act can be a powerful tool in digging out further information, as can the Equality Act, while recognised trade unions have a right to disclosure of information for collective bargaining purposes – which would certainly include staffing levels, for example. They also have a right to be consulted, in good time, and with a view to reaching agreement on avoiding or reducing any redundancies which may be threatened. Be careful, though, because just because staff reductions are negotiated doesn't necessarily mean they will not lead to unsafe staffing levels or skills mixes.

You have a right to elect health and safety representatives who have statutory rights to inspect workplaces, obtain information, sit on a safety committee and be consulted on health and safety matters. They also have a legal right to make a "protected disclosure", as do [whistleblowers, subject to certain conditions](#). If you think you are being treated detrimentally as a result of such activities, you must immediately take advice. If you raise concerns collectively, victimisation may be less likely.

Duty of care dilemma

You are the named nurse in a large nursing home. You believe that due to gradual changes in the dependency levels of those admitted to the home, additional staffing is now essential, or else the home will place patients at risk.

The head of home responds by saying he has spoken to head office and that if you are uncomfortable about staffing levels they will transfer you to another home.

What should you do?

5. Whistleblowing: protecting others and looking after yourself

5.1 Whistleblowing -- legal protection for raising concerns?

Every NHS employer and other provider of health services has a policy that requires their staff to draw management attention to concerns about the environment of care or risks to the health and safety of patients, staff or members of the public. If the concerns raised are sufficiently urgent or important, or the informal process fails to address the concerns in a timely manner, then staff might have to use the employer's "whistleblowing" procedure. A copy will be on your employer's web Intranet.

The [NHS Constitution](#) commits "to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998".

The [NHS Terms and Conditions of Service Handbook](#) (Section 21) confirms that raising concerns is a contractual right and duty. It states: "All employees working in the NHS have a contractual right and a duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest."

NHS Employers have drawn up a [Speaking Up Charter](#), supported by professional bodies and unions, which has the following principles:

- Safety should be at the heart of all care and is the responsibility of everyone involved in the provision of health and social care services.
- Ensuring all individuals are treated in a service which is open to feedback, and encourages as well as supports its staff to raise concerns.
- Staff engagement in the development and delivery of our services is fundamental.
- Registered health and social care workers have a duty to follow their professional codes of conduct, but equally organisations are encouraged to develop their own statement of values for all staff.
- Individuals should always feel free to raise concerns through local processes and be supported to do so.
- Policies should be developed and continuously promoted.
- Compromise agreements containing clauses seeking to prevent disclosures protected under the PIDA 1998 are not acceptable.
- Adequate training and support is provided for managers so that they understand their role and responsibilities in handling concerns raised with them and are able to respond appropriately.

In addition, professional regulators provide guidance, such as the NMC's [Raising and Escalating Concerns](#) and the GMC's [Raising and Action on Concerns about Patient Safety](#).

However, despite the words of whistleblowing policies, too many organisations do not praise those who raise such concerns, and instead often victimise them. This may take the form of being suspended, bullied, ostracised or subjected to counter-allegations of poor practice, which may conclude in disciplinary or even professional conduct proceedings.

While there are organisations in which, especially in the aftermath of the Francis Report, it is recognised that an open transparent culture that values staff and where concerns can be freely raised is essential, there is still a culture of fear in too many others.

This is often one aspect of a toxic management culture in which safe quality of care has been subordinated to other pressures, such as financial austerity and targets (or profits in the case of private providers).

In theory, healthcare workers who whistleblow have statutory protection from victimisation through the Public Interest Disclosure Act 1998 (PIDA). The Act protects all employees, workers, contractors, trainees or agency staff who make a disclosure in good faith (even if later it turns out to be untrue) and believe that at least one of the following tests is met:

- that a criminal offence has been or is likely to be committed
- that someone is failing, or will fail, to comply with legal obligations including the duty of care
- that a miscarriage of justice will occur or has occurred
- that there is a health and safety risk or there is a risk of damage to the environment
- that information about these issues has been, or is likely to be, deliberately concealed

However, the obstacles to effective whistleblowing are many. They include NHS employers who tried to use gagging clauses in the “compromise agreements” which normally accompany any settlements for compensation. The Francis Report recommended that these are banned, and the government says it is looking at how to give whistleblowers more protection.

Judicial interpretation of the law can also leave whistleblowers vulnerable. For example, in a high profile case in 2012, Jennie Fecitt and nurse colleagues had an important claim that they were being victimised for whistleblowing rejected on the grounds that the employing Trust could not be held responsible (“vicariously liable”) for the bullying they suffered after whistleblowing. This decision will be reversed in forthcoming legislation.

Duty of care dilemma

You are a pharmacist. You have repeatedly raised concerns that the hospital's system for destroying out of date medicines is faulty. Now a death has occurred from the use of out of date medication.

You are very upset about this and raise your voice in a discussion with the head of department. You are then suspended for inappropriate behaviour and are then told you may be disciplined for raising concerns maliciously.

What should you do?

5.2 Whistleblowing in practice

In theory, therefore, healthcare workers are protected by whistleblowing procedures, but in practice there can be complications, and before using them staff are urged to take advice from their union official or professional body (or a lawyer) and to carefully check what their local whistleblowing procedure actually says. If you are concerned that the advice from your trade union may not be comprehensive or correct then check our guidance on getting the best from your trade union at www.thedutyofcare.org.

[Public Concern at Work](#), the whistleblowing charity, has a comprehensive range of background materials and advice on whistleblowing across all sectors, including a guide to the PIDA. In partnership with the Social Partnership Forum, it has also published [Speak up for a Healthy NHS](#), which sets out expectations of how managers should respond when staff raise concerns. It states that when responding to a member of staff who raises a concern employers should respond as follows:

- Thank the staff member for telling you, even if they may appear to be mistaken.
- Respect and heed legitimate staff concerns about their own position or career.
- Manage expectations and respect promises of confidentiality.
- Discuss reasonable timeframes for feedback with the member of staff.
- Remember there are different perspectives to every story.
- Determine whether there are grounds for concern and investigate if necessary as soon as possible. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, put your response in writing.
- Always remember that you may have to explain how you have handled the concern.
- Feedback any outcome and/or remedial action you propose to take to the whistleblower but be careful if this could infringe any rights or duties you may owe to other parties.
- Consider reporting to your board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed.
- Record-keeping – it makes sense to keep a record of any serious concern raised with those designated under the policy, anonymising these where necessary.

[Patients First](#) is a network of health service nurses, doctors and other staff who have raised concerns and whistleblow at work. It is a membership organisation and campaigns to improve real protection for whistleblowers

Duty of care dilemma

In the report of the first Francis inquiry into Mid Staffs it was noted (para 43) noted that a consultant was asked “to alter an adverse report to the coroner”. This “calls into question how candid the Trust was prepared to be about things that went wrong”.

If you were put into the same invidious position as that consultant, what would you do?

and create an NHS where there is no need to blow the whistle and fear the consequences.

The CQC, which has statutory powers to intervene, has a whistleblowing helpline which can be used anonymously, and following intense criticism of the CQC during and after the Mid Staffordshire NHS Hospitals Trust Public Inquiry it may be a little more robust and receptive to those raising concerns. It also publishes [Raising a concern with CQC. A quick guide for health and care staff about whistleblowing](#).

Other organisations with which it might be appropriate to raise particular kinds of concerns include the [Health and Safety Executive](#) and, for children's services, [Ofsted](#). [Mencap](#) runs a whistleblowing helpline for NHS whistleblowers, but it has had mixed reviews from its users.

Just as concerns can and should wherever possible be raised collectively as well as individually, whistleblowing procedures can be used collectively too, though for individuals to gain legal protection it is essential they identify themselves.

It is more effective to understate rather than overstate your case, and, however distressing the circumstances, make sure that your tone and language are calm, that you don't abuse anyone and that no patient can be identified. Bear in mind that anything you raise may become the subject of proceedings at a later stage.

Box 5 - Three things to do before whistleblowing

Whether collectively or individually, it is important that *before raising concerns outside your employer*, you:

- can demonstrate you have tried to raise your concerns within your employer without success;
- have prepared a short summary – no more than four pages - of the key concerns, how you have tried to raise them, what you seek and the evidence you have;
- are able to support your claims with evidence

Be careful about how you use the media -- especially social media. People sometimes act on Facebook and Twitter as they might in a private conversation with a friend, but it is better to ask yourself before committing anything to social media whether there is anyone in the world you would not like to read it: if the answer is yes, don't say it!

Staff in some sectors have been specifically warned about criticising their employer on social media, and some trade unions have issued advice about this contentious and developing area. Ensure that you are familiar with your employer's policies on IT, social media and confidentiality.

5.3 Looking after yourself as well as others

Raising concerns at work can feel good because it is “the right thing to do”, especially if your colleagues support you or management accept your concerns are justified. But it can feel stressful, especially if some colleagues keep their distance because they fear you may be seen as a “troublemaker”, or if your employer responds negatively.

Whatever the response, you may need support from friends, family and your union representative (or lawyer). You need to be prepared for a backlash and may need personal resilience to keep going. Here are some tips to help you do this:

- **Keep the focus on the issue you raised concerns about** - whatever your employer does.
- **Anticipate what could happen.** Colleagues who said they would support you sometimes don't. Your employer may mislead you. Managers or HR who have privately sympathised may turn against you. Expect to be surprised.
- **Try to win support from workplace colleagues -- raise concerns collectively if possible.** Regular time out to discuss the pressures of work, in your ward, department, laboratory or health centre should be an essential part of surviving in a pressured work environment.
- **Draw support from friends and family.** A good union representative or official (or a good manager) will support you and give advice. But if they are busy (and if they are good they will be) you also need to ensure your family and friends know about your situation and give you moral, emotional and practical support. It is very important, especially if you live alone, to meet other people and not to isolate yourself.
- **Don't be afraid to get advice or support from your GP if things get stressful.** GPs can refer you for counselling and ask your employer to refer you to Occupational Health. It can be very important that as early as possible your GP is made aware of health issues linked to work. Your employer should refer you to their Occupational Health service.
- **Suggest a workplace stress risk assessment or wider survey around the concerns you raise.** Being able to demonstrate that you are not the only person with concerns or affected by pressures at work can be very helpful and make you feel less isolated.
- **Get good advice and keep yourself mentally healthy.** This can be especially challenging if you are suspended, as the change from having a busy working schedule to sitting at home, supposedly forbidden to contact work colleagues about the issue that you raised, can be demoralising and disorientating. So, set a daily routine for yourself and try and stick to it, even if you don't feel like it.
- **Don't give up on your rights.** For instance -- and, again, particularly if you have been suspended -- liaise with HR to organise access to your personal

items, collect relevant evidence from your files stored electronically and so on. Make sure your union official supports you in this.

- **And remember: you are not a villain!** On the contrary, you are behaving responsibly because you care. You are doing what you feel is the right thing to do.

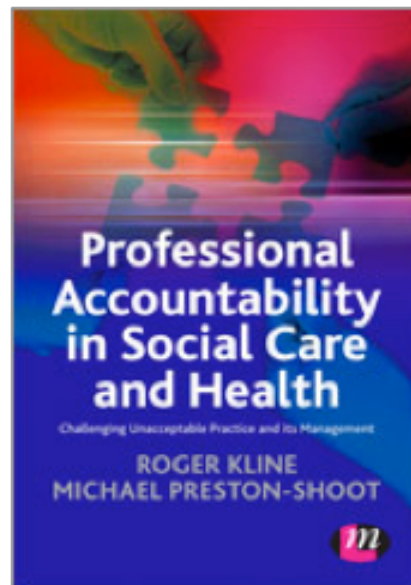
During this period you may gain new friends as well as lose some workplace friends you thought would always be there for you. They may be frightened, especially if bullying is rife at work and they may have been advised formally by management not to contact you. Don't let this get you down: true friends will stay in touch.

This sort of challenge is hard to manage at the best of times, and under enough pressure we lose our perspective and capacity to think past these overwhelming feelings.

Dealing with your anger can be especially tricky. When you are raising concerns, especially if you meet resistance or even retaliation, then you may quite rightly be advised "don't get mad, get even".

That's not bad advice if it means don't shout at people or don't send late night furious emails. However that doesn't mean you are not entitled to show how angry you rightly are that having done the right thing you may suffer consequences for doing so. Just find ways of doing it that don't confuse the focus on the original issues you raised. You can find some useful tips about resilience [here](#).

From one of the authors of this handbook ...



An excellent book for final year social work students. *Sue Jones, Manchester Metropolitan University*

A good book, solid information with useful insight. *Dr Dean-David Holyoake, Wolverhampton University*

This is one of the most appropriate books on the market currently. I found this book to be most inspiring and informative on an area that is pertinent to any social work practitioner from newly qualified to advanced practitioner / manager. *Robert Bielby, Faculty of Health and Social Care Sciences, Kingston University*

Very easy book to read and understand. I particularly liked the explanations of Duty of Care. *Sue Williams Division of Social Work, School of HASS, De Montfort University*

6. Building a safer future for healthcare staff and patients

This handbook is intended to help healthcare professionals and other staff to honour their principal duty -- their duty of care to patients -- even in the most adverse circumstances. The cost-cutting, fragmentation and privatisation of NHS services is not making those circumstances any easier -- far from it.

So we recognise that, alongside dealing with the world as it is, there is work to be done to improve it. Indeed, while supporting and providing advice for whistleblowing, for example, what we really need are workplaces in which whistleblowing is unnecessary.

Good healthcare combines a sound framework of clinical governance with effective management in a culture of collective and individual responsibility and mutual support. It provides an environment where a 'just culture' ensures learning from errors, staff concerns and patient complaints.

Good employers understand that staff health and wellbeing are prerequisites of good outcomes for patients -- so good healthcare providers need to be good employers. In such an environment there would be no need to write a handbook such as this because staff and patients concerns would be openly raised and acted upon.

6.1 The framework of clinical accountability for employers

After the [Bristol Royal Infirmary scandal](#) a decade ago, the government took steps to improve the detection of adverse clinical incidents and the sharing of good practice and bad experience through open investigation. The intention was to create a 'no blame' culture so that the NHS as a whole could learn from mistakes and prevent future ones.

Obviously, the fact that Mid Staffs happened at all is proof that things didn't work out that way, but that doesn't mean the framework put in place after Bristol had no value. On the contrary, it needs to be applied more consistently and rigorously and combined with other changes to enable cultural change of the kind that the Francis inquiries showed to be essential.

The Health Act 1999 made the quality of service a core duty of NHS Trusts and uses clinical governance to help achieve this, [defining it](#) as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

Duty of care dilemma

In the report of the first Francis inquiry into Mid Staffs it was noted (para 43) that a consultant was asked "to alter an adverse report to the coroner". This "calls into question how candid the Trust was prepared to be about things that went wrong".

If you were put into the same invidious position as that consultant, what would you do?

Each employer should have its own arrangements for monitoring and improving the quality of health care and involving staff at all levels through:

- clinical audit and supervision
- protected time and resources for training and continuing professional development, including for part-time and shift workers
- ensuring staff are confident about raising concerns and admitting errors and;
- ensuring patients and carers are confident about raising concerns and complaints about their care.

Clinical governance has the duty of care at its core. An essential part of clinical governance is creating an environment in which the raising of concerns by staff or patients is welcomed. Good management draws on the considerable research evidence that “staff engagement”, real team working, and openness about mistakes improves clinical outcomes.

6.2 Learning organisations and leadership

There is now substantial research showing what factors help create good health outcomes and safe practice. Whilst sufficient resources and appropriate skill mix are crucial, good leadership and organisational culture are also a pre-condition of good safe care.

The nature of leadership in healthcare organisations is crucial:

When patient safety breaks down it is usually caused by clinical systems and processes rather than individuals.....the leader’s job is (to help) create an environment in which people are given the right tools for doing their jobs and are so comfortable with their role in the organisation that they hold themselves accountable.

[‘Personal accountability in healthcare: searching for the right balance’](#). Robert Wachter, 2012, *The Health Foundation*

Another researcher concludes:

The current focus on improving care by redesigning systems, tasks and workforce necessarily emphasises the multiple factors underpinning errors, relies on reporting systems for capturing errors, and advocates a “blame free” environment so that staff will report their mistakes or near misses. This approach examines system factors as causes of errors rather than individuals. Evidence from other industries and disciplines supports this approach.

[‘Creating a “no blame” culture: have we got the balance right?’](#), M. Walton, *Qual Saf Health Care* 2004;**13**:163-164

There is a large body of research that has demonstrated that a “transformational leadership” style that enables, facilitates, and models good practice is more effective than a “command and control” leadership

Learning about learning organisations

For an international literature review about how employee involvement can improve public service productivity, go [here](#).

For an outline of The Best Workplace approach that Public World is developing in partnership with the Swedish social enterprise Alamanco, go [here](#).

And for a detailed case study of the transformative effect of the work done by Public World partner Alamanco in Swedish health and social care go [here](#).

style, and that “embedding this particular leadership approach in the culture of teams predicts high levels of morale, wellbeing, increased productivity and ability to successfully implement change.” ([‘Leadership: Commitment beats control’](#), Beverley Alimo Metcalf, *Health Service Journal*, 22 February, 2010.)

Organisations applying such principles increase the likelihood that near misses and incidents are promptly reported and discussed, and create a culture in which staff are expected to raise concerns and patient complaints are welcomed as learning opportunities. When such an approach fails, then whistleblowers should be welcomed and listened to, not treated as troublemakers against whom the employer closes ranks.

6.3 The link between good management and clinical outcomes

A ten year research project by highly respected occupational psychologists then at Aston Business School ([NHS Staff Management and Health Service Quality](#), Michael West and Jeremy Dawson, 2011), funded by the Department of Health, concluded:

Good management of NHS staff leads to higher quality of care, more satisfied patients and lower patient mortality. Good staff management offers significant financial savings for the NHS, as its leaders respond to the challenge of sustainability in the face of increasing costs and demands.

The same research found that differences in human resources practices account for 33% of the variation between hospitals in deaths within 30 days of emergency surgery and after admission for hip fracture. It found strong links between staff ‘engagement’ and clinical outcomes, and demonstrated that well structured appraisals, good team working, supportive line management, sufficient access to appropriate training, learning and development, and clear team goals are all good predictors of patient satisfaction, patient mortality, staff absenteeism and turnover.

Other studies reached similar conclusions. (See, for examples, West & Dawson 2012: [Employee Engagement and NHS Performance](#), Kings Fund; West & Dawson 2011: [Research on assuring the Board that the care provided to patients is safe](#), Aston Business School; Prins et al 2010: [Burnout and engagement among resident doctors in the Netherlands: A national study](#), Medical Education; Laschinger & Leiter 2006: [The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/ engagement](#), Journal of Nursing Administration.)

There is also strong evidence -- as common sense would predict -- of a link between NHS staff wellbeing and their performance, productivity and effectiveness. The [Boorman Review](#) into NHS staff health and wellbeing, commissioned by the Department of Health, found many NHS staff did not believe their wellbeing was important to their employer, even though better

Duty of care dilemma

In the A and E ward where you work two members of clinical staff are repeatedly rude to patients and dismissive of any concerns they raise.

When you query their approach, as a colleague, you are told it is none of your business.

Now a relative has complained to you about this as you are working.

What should you do?

staff health and wellbeing led to “improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence”. Dame Carol Black’s 2008 report on the health of the UK workforce, [Working for a Healthier Tomorrow](#), also demonstrated the business benefits of wellbeing, especially relevant given high stress levels in healthcare.

The NHS Commissioning Board published [Compassion in Practice](#), the Chief Nursing Officer’s strategy, endorsing this approach: “To ensure that patients receive good care, we all need to care about our colleagues. If we feel supported and cared about, we are enabled to support and care about our patients. Leadership is key. Leaders and managers need to create supportive, caring cultures.”

6.4 A sea change is needed

To sum up: Being open about mistakes improves healthcare. Good management culture improves health care. Being responsive to patient complaints and staff concerns improves healthcare. Bullying and macho leadership are bad for healthcare and lead to many little disasters as well as catastrophic ones like Mid Staffordshire.

What is clear is that despite an apparent consensus around some of these issues -- see, for example, the King’s Fund publication [Leadership and engagement for improvement in the NHS: Together we can](#) -- many NHS employers are still a long way from demonstrating the sort of leadership and management that the evidence suggests is best for patients.

The [Speaking Up Charter](#), which NHS Employers endorsed, states:

“This charter outlines a commitment to work more effectively together to create a *just* culture which is open and transparent. A *just* culture ensures individuals are fully supported to report concerns and safety issues, and are treated fairly, with empathy and consideration, when they have been involved in an incident or have raised a concern. ... We aim to develop a culture that provides for an environment where people feel able to raise concerns, be they staff, users of health and social care services, their relatives, or anyone else.”

A “healthy” healthcare provider demonstrates characteristics as set out in the box on the following page. Trusts that fall short of these, are likely to let down patients.

Box 6 - Characteristics of a 'healthy' health care provider

Element of safety culture	Characteristics
<u>Open culture</u>	Staff feel comfortable discussing patient safety incidents and raising safety issues with both colleagues and senior managers
<u>Just culture</u>	Staff, patients and carers are treated fairly, with empathy and consideration when they have been involved in a patient safety incident or have raised a safety issue.
<u>Reporting culture</u>	Staff have confidence in the local incident reporting system and use it to notify healthcare managers of incidents that are occurring, including near misses. Barriers to incident reporting have been identified and removed: <ul style="list-style-type: none"> • staff are not blamed and punished when they report incidents • they receive constructive feedback after submitting an incident report • the reporting process itself is easy
<u>Learning culture</u>	The organisation is committed to learning safety lessons, communicates them to colleagues and remembers them over time.
<u>Informed culture</u>	The organisation has learnt from past experience and has the ability to identify and mitigate future incidents because it learns from events that have already happened (for example, incident reports and investigations).

Reproduced from '[Patient Safety First. Implementing Human Factors in healthcare](#)' (undated)

6.5 The impact of the Health and Social Care Act 2012

The UK coalition government's radical changes to the NHS appear to be precisely the sort of large scale reorganisation that the first Francis inquiry report warned about. The fragmentation and privatisation that is likely to follow

these changes create a number of potentially significant risks especially at a time of cuts to NHS spending. The Act is likely to impede effective regulation and planning and obstruct the effective sharing of information and development of collective knowledge among employers.

Before the Act came into force, an [authoritative survey](#), reported in *Nursing Times* found: “Nearly half of hospital chief executives believe regulators and the NHS governance system would miss a Mid Staffordshire-style care scandal if it occurred today.”

This handbook seeks to help staff, managers and patients be more aware of our rights and obligations and to become more assertive in speaking out about them. However, we recognise that whilst individuals and groups of staff and patients can make a difference, we also have to consider the wider employer and system-wide context staff work in.

We are clear, however, that raising concerns about national changes is NOT an alternative to also standing up for what is right in your own local hospital, ward, department or clinic now. We need to do both.

www.thedutyofcare.org

For updates and useful tools to help staff, patients and carers improve jobs and service standards visit our dedicated web page at Public World.

And to comment on this handbook or to get in touch please email admin@publicworld.org