Freedom to Speak Up – Qualitative Research

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Report - 19 November 2014

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Executive Summary - Freedom to Speak Up – Qualitative Research

This qualitative research was commissioned by The Freedom to Speak Up Review, and was carried out the University of Greenwich.

The research aimed to:

- gain an understanding of views and attitudes to whistleblowing in the NHS held by those in various roles in the whistleblowing process - i.e. whistleblowers, frontline staff, managers, directors, regulators, unions, and whistleblowing support groups.

- identify strengths and weaknesses in the implementation of whistleblowing policies in the NHS.

The research consisted of two parts: a desk based analysis of whistleblowing policies, and an interview based analysis of how whistleblowing policies are implemented in the NHS.

A representative sample of 21 whistleblowing policies was analysed, and a total of 37 interviews were carried out (14 whistleblowers, 11 HR Directors, 4 other Directors, and 8 other roles - i.e. case handler, union, support group, coach, solicitor) in September and October 2014. Anonymous transcripts were analysed. The researchers worked under strict confidentiality and was approved by the University of Greenwich Research Ethics Committee (UREC 13.5.5.9).

The whistleblowing policies we analysed showed a huge variation, and on important aspects did not always meet standards of good practice.

The analysis of the interviews showed a polarising trend on most elements of the whistleblowing process. We conclude from this that within the NHS there are two models emerging of how whistleblowing policies are implemented - without making any claim about the prevalence of any of these two in the total population of NHS Trusts.

- One model entails a gatekeeper approach to whistleblowing procedures. It tends to use a strict legalistic definition, and proponents worry about misuse and mixing up of grievance-like situations with wider concerns. This approach is focused on investigating major wrongdoing only. There is a tendency to attribute responsibility for failed processes on others.

- Another model that is developing takes a broad and engaging approach to whistleblowing. It tends to entail a low level of uncertainty avoidance with regard to people who raise concerns. It accepts a wider range of concerns as qualifying for the procedure to be invoked, and also regards grievance-like situations as indicators of potential malpractice.

The emerging engagement model for raising and responding to concerns shows promising developments that avoid many of the problems of the gatekeeper model. However, these developments are in an experimental phase.

Our interviews indicated that in the NHS a very wide spectrum of concerns are raised. There was evidence that management was adapting their procedures to a perceived need within the organisation, but this was only in a small number of Trusts and was still in its early stages of implementation.

There are salient changes to the roles of and expectations towards HR, unions, CQC, and other stakeholders with regard to key functions in the process of raising and responding to concerns.

The report asks the Review to consider the following:

1. Develop and validate visible aspects of raising and responding to concerns along the engagement model.

2. Integrate the engagement model for raising and responding to concerns into leadership development programmes in a way that embeds this approach to concerns into notions of the learning organisation, staff engagement, compassion, anti-bullying, improving patient care, and career development.

3. Develop a more unified whistleblowing policy across the NHS that meets standards of good practice.
   A suggested approach is to integrate learning from engagement type of approaches to raising and responding to concerns, with input from the CQC and other stakeholders to contextualise the Code of Practice from the Whistleblowing Commission.

4. Develop and validate configurations of indicators for monitoring the effectiveness of raising and responding to concerns.
   This will include methods to monitor the prevalence of channels used to raise and respond to various types of concerns, and the methods to prioritise and enquire into concerns.

5. Optimise the roles of and relations between various players in the whistleblowing process, in particular HR and CQC.

Freedom to Speak Up – Qualitative Research

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Report - 9 November 2014

1. Introduction

This is the report from a qualitative research study commissioned by The Freedom to Speak Up Review, which set out to be an independent review into creating an open and honest reporting culture in the NHS.

This qualitative study aimed to:

- gain an understanding of views and attitudes to whistleblowing in the NHS held by those in various roles in the whistleblowing process - i.e. whistleblowers, frontline staff, managers, directors, regulators, unions, and whistleblowing support groups.

- identify strengths and weaknesses in the implementation of whistleblowing policies in the NHS.

The research consisted of two parts: a desk based analysis of whistleblowing policies, and an interview based analysis of how whistleblowing policies are implemented in the NHS.

This research is qualitative. Sampling techniques were designed to ensure validity of the research. We strived for validity that would allow our qualitative research findings to represent as much as possible the variety of views and approaches to, and perceptions of whistleblowing in the NHS. Our research design does allow any conclusions as to what extent any particular view, approach, or perception is representative for the whole of NHS organisations.

The report is structured as follows. In section two we present the methodology and findings of the desk based analysis of whistleblowing policies. We then present in section three the methodology and findings of the interview based research. We present our conclusions from these two research parts in section four. Finally, based on these conclusions we formulate considerations for the Review team in section five.

2. Analysis of whistleblowing policies

Whistleblowing policies provide the norm for whistleblowing behaviour in an organisation. Those who want to raise a concern as whistleblowing will look for guidance and instructions in the policy, as will those who receive concerns, investigate concerns, or oversee due process within the organisation.

Hence if policies are to drive behaviour and interactions within an organisation, it is important that policies represent the elements and processes considered to be best practice.

To find out whether this was the case for whistleblowing policies in the NHS, we undertook an analysis comparing NHS whistleblowing policies with standards on which there is an international consensus best practice consensus.

2.1 Methodology

A ranking of 233 Trusts was compiled by the Review Team based on results from 7 questions from the 2013 staff survey relating to raising concerns, error reporting, bullying, and harassment. Thirty Trust were randomly selected from this list (10 top third, 10 middle third, 10 bottom third). These were contacted and asked to send their whistleblowing policy. The Review Team received 21 whistleblowing policies: 6 top, 7 middle, 8 bottom. These 21 policies were analysed by the University of Greenwich research team.

For this analysis, a framework of 17 items was used. These were derived from the framework from analysis of international whistleblowing guidelines[1], and from the whistleblowing Code of Practice set out by the Whistleblowing Commission[2]. Most of these items overlapped, which increases the validity of the framework used for the analysis of NHS Trust whistleblowing policies. We present this framework together with the findings from the analysis using the framework. We have adopted as a norm for each item what is considered best practice amongst scholars and practitioners.[3]

2.2 Findings

2.2.1 Who does the policy apply to?

Whistleblowing policies should make clear that they can be used for all who work at the organisation regardless of their employment status (employee, volunteer, contracted worker, student, ...).

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[1]   Vandekerckhove, W. and Lewis, D. (2012). 'The content of whistleblowing procedures: A critical analysis of recent official guidelines', *Journal of Business Ethics* 108(2), 253-264.

[2]   Whistleblowing Commission (2013). *Code of Practice*. London, Public Concern at Work.

[3] See footnotes 1 and 2.

The policies in our sample fell into two groups, with one set of policies clearly indicating that staff includes agency workers, volunteers, and employees of contractors. Other policies are not clear at all to who they apply.

For example, 'staff' and 'all employees' are interchanged without further description; a policy used the wording 'individuals directly employed by the Trust' throughout the text and only broadened this up in the last paragraph; a number of policies gave a broad description on the header sheet under 'target audience' but not in the text itself.

2.2.2 What is the scope of concerns that can be raised?

Policies should use a broad category of concerns that are relevant to the type of activities of the organisation.

In our sample of NHS policies we saw very good examples of contextualised distinctions between grievances and public interest concerns. One policy had a table giving examples of each, e.g. 'an employee's complaint about the type of work he or she is being asked to do that is not covered by his or her contract' would be a grievance, whereas 'a disclosure that an individual has been instructed to carry out actions that he or she believes to be illegal' is a public interest disclosure; or 'An employee's complaint about the hours that he or she is expected to work' would be a grievance, whereas 'A disclosure that the requirements imposed on a group of staff breach the working time legislation' is a public interest disclosure. Such a contextualised table gives more confidence in a policy than an abstract definition.

However, many policies simply take over PIDA stipulations without any contextualisation. There were also policies in our sample that merely put 'public interest' as a requirement, but give no further description of what that is.

2.2.3 Does the policy identify recipients at successive tiers?

Good policies identify multiple recipients at various hierarchical levels, as well as appropriate external and regulatory recipients.

The policies in our sample did identify multiple tiers where staff can raise a concern. Identified recipients at top level include CEO and/or non-executive Directors. All but one also identified external recipients.

Some policies included awkward lists, i.e. omitting CQC from recipients, or listing regulators together with advice organisations (without making any distinction). A small number of impressive whistleblowing policies also mentioned possibilities to raise a concern to an MP or the media. Other policies however include a warning against 'rash disclosures' to the media, or even mention media disclosures as unjustified external disclosures.

2.2.4 Is the procedure operated in-house or through an external provider?

All policies we have seen are operated in-house, i.e. there is no whistleblowing hotline operated by an external provider. All policies in our sample did however mention the availability of external advice. This included unions, the NHS Whistleblowing Helpline operated by Mencap, and Public Concern at Work.

2.2.5 Does the policy describe the process of what happens with concerns that have been raised?

Good policies allow various modes for raising concern (verbal, written, electronic) and will explain organisational processes of what is done with concerns that have been raised, i.e. how these are investigated and how communication with whistleblowers proceeds.

Most policies in our sample opt for raising concerns verbally with the line manager, but in writing beyond that. One policy included a specific form in its appendix. Another two policies left it open at any point how staff could raise a concern but required managers to log this. The sample showed a huge variety in how concerns are processed.

2.2.6 Is the policy clear on confidentiality and anonymity?

Whistleblowing policies need to explain the difference between confidentiality and anonymity, guarantee confidentiality but also accept concerns that are raised anonymously.

The policies in our sample often confused confidentiality and anonymity, with the worst examples either not mentioning anonymous concerns at all, or writing 'If you wish to retain anonymity your confidentiality will be preserved.' The best examples were policies that encouraged openly raising concerns, guaranteed confidentiality if requested by the person raising the concern, and also offered the possibility of anonymously raising a concern but at the same time explained the implications of that for communication and protection.

2.2.7 Is whistleblowing a right or a duty?

Policies need to strike an appropriate balance between whistleblowing as a right vs a professional duty. The acknowledgement of whistleblowing as a right through legislation opens the door to the imposition of whistleblowing as a duty through internal organisational policies.[4] To a certain extent this is even conceptually desirable. However, such an imposition risks bringing about unreasonable expectations on employees, e.g.

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4   Tsahuridu, E. and Vandekerckhove, W. (2008). 'Organisational whistleblowing policies: making employees responsible or liable?', *Journal of Business Ethics* 82(1), 107-118.

making them liable for not raising a concern in organisational cultures that are unsafe with regard to raising concerns.[5]

A small number of policies in our sample were problematic in this regard. For example, one policy stated that raising concerns about patient safety was a professional duty but that it was not allowed to do so if the disclosure itself is a criminal offence. Another example is where raising concerns is described as a responsibility under the title 'duties and responsibilities' but no-one seems to have a responsibility to prevent reprisal.

2.2.8 Are the policies clear on protection and sanctioning reprisals?

Policies need to establish the organisational framework to make raising a concern safe. To that end, policies need to guarantee protection from reprisal and explicitly state reprisals will be sanctioned.

Nearly all policies in our sample include a statement that those who raise a concern will not suffer detriment, often with the wording that reprisals will not be tolerated. However, we favour the stronger, positive wording that reprisals against those who raise a concern will be sanctioned.

About half of the policies make no mentioning of sanctioning reprisals. Two policies used problematic wording. One stated that reprisals had to be reported as grievance, and that disciplinary action would be taken if a concern was raised 'frivolously, malicious, or for personal gain'. Another stated that one 'should raise without fear' and although it said reprisals would be sanctioned, it did so in the same lines as sanctioning unjustified disclosures as a disciplinary matter.

2.2.9 Does the policy avoid referring to motive?

One of the recent changes to PIDA was the removal of the 'good faith' test. This followed a consensus amongst whistleblowing scholars[6] and increasingly also amongst policy makers[7] that malicious whistleblowing is raising concerns that are knowingly false. The opposite is raising a concern of which one has a reasonable belief it is true. Motive-tests introduce arbitrariness in whistleblowing protection schemes and are counter-productive.

It was striking to see that almost all policies included wording like 'good faith' and 'genuine concern', which carry strong connotations of motive. Three policies even went as far as explicitly stating good faith, genuine concern, and honesty were conditions for protection. We also saw policies that worked consistently with the recommended

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[5]   Vandekerckhove, W. and Tsahuridu, E. (2010). 'Risky rescues and the duty to blow the whistle', *Journal of Business Ethics* 97(3), 365-380.

[6]   Peters, P. (2014). 'Motivations for whistleblowing: personal, private, and public interests', in AJ Brown, R.E. Moberly, D. Lewis and W. Vandekerckhove (eds) *International Handbook on Whistleblowing Research*, Cheltenham, Edward Elgar, 207-229.

[7]   The Council of Europe Recommendation on whistleblower protection can be seen as the most recent culmination point of a consensus that had been growing over the last decade. See Recommendation CM/Rec(2014)7 of the Committee of Ministers to member States on the protection of whistleblowers, 30 April 2014.

'reasonable belief', but others introduced confusion by using 'genuine' or 'good faith' in addition to 'reasonable belief'. One policy had an original take on this by stating first using 'reasonable belief' but further on stating employees had to raise 'genuine concerns that you reasonably believe are in the public interest'.

2.2.10 Are whistleblowers rewarded?

None of the policies in our sample mention rewards. This is not surprising as there is no consensus on the desirability of rewards (or its effectiveness) in the financial sector, let alone for health care organisations.

2.2.11 Are whistleblowers encouraged to seek independent advice?

It is generally assumed that whistleblowers can benefit from independent advice on how to raise a concern so that they are aware of conditions and requirements at the various stages of the process.

In our sample, all but two policies gave at least two suggestions where staff could get independent advice on how to raise a concern or use the policy. This always included unions, and either or both the NHS Whistleblowing Helpline (operated by Mencap) or Public Concern at Work. One policy also listed the CQC as an advice line.

2.2.12 Is there any training provided in relation to the policy?

Research suggests that the aspect of whistleblowing where organisations need to develop most is that of appropriately responding to concerns that are raised (Vandekerckhove et al 2014).

Although there is no clear norm as to what constitutes effective training for this, the policies in our sample did not give this item a lot of thought, or left it unspecified how they see links with leadership training.

Four policies mentioned some management training. Two of these however only provided training for designated leads, not for line managers.
A number of policies included absolutely nothing on training.
Three policies said training consisted of policy awareness only. Two of these mentioned this was to be done at induction.
Two policies stated 'training' means updating information on the intranet, and two policies explicitly stated no specific training was needed. One policy seemed to totally miss the point of training by suggesting it is something done after the facts: 'Human Resources Business Partners and Senior Managers across the Trust will be responsible for training and education relating to compliance with this policy in the event that an individual need arises'.

2.2.13 How are concerns registered?

There was a huge variety on this item in our sample policies. A good number did mention the registration of a concern that had been raised as a management responsibility. Others were less stringent. One policy asked managers to 'consider reporting to the Board'. Another policy did not indicate when or how managers needed to register concerns, but did set out procedures and minuting specifications for 'investigative meetings' with whistleblowers.

2.2.14 How is the policy monitored and who reports on that?

The policies in our sample also showed a huge variety on this item. Monitoring and reporting on how the whistleblowing procedures and policies work is clearly an element that is not thought through or where Trusts lack established practice.

One policy stated it would monitor its whistleblowing policy through the number of incident reports. Another said it would do this by looking at grievance and ET data. Yet another stated monitoring would be based on the staff survey data. There was also a policy that stated there were indicators, without specifying what these were.

On the other hand, there were also some good examples where policies explicitly stated monitoring would be based on number and nature of the concerns raised, together with other identified indicators measuring organisational culture. Other good practice seen in sample policies was explicitly stating who would report to who and when. However, one policy stated HR would annually audit itself.

2.2.15 Who has overall responsibility for the policy?

The majority of policies in our sample identified HR (or the Director of Workforce) as having overall responsibility for the policy.

Exceptions were: non-executive Director, Chief Nurse, Governance Team, CEO, Director of Corporate Governance & Facilities.

2.2.16 Are unions and other stakeholders involved in developing and monitoring the policy?

All policies in our sample had involved 'staff side' in the latest update of the policy. Unions were also consistently mentioned as a source of advice for staff who wanted to raise a concern.

2.2.17 Does the policy foresee a review?

All policies in our sample mentioned the date of the next policy review. This was nearly almost in 3 years time. For two policies that was 2 years, and for one this was 5 years.

3. Interview based research

Whistleblowing policies provide the norm for whistleblowing behaviour in an organisation. However, organisational practices often divert from the norm represented in a policy. Although our sample of whistleblowing policies analysed in the previous section represented Trusts across the NHS staff survey ranking (cf. 2.1), there was no immediately apparent correspondence between how well these policies scored against our framework and how the Trusts' respective places on the staff survey ranking. To establish whether or not there is a correlation would require further research. However, from our analysis such a correlation is not obvious.

Hence to gain insight into the realities of whistleblowing in organisations, it is necessary to ask people in different roles how they perceive the whistleblowing process rather than the policies.

To gain that insight into the realities of whistleblowing in the NHS, we undertook interview based research. We sought to gather as many different views as possible within a short time frame, and followed an inductive process to analyse interview transcripts and arrive at an informed view on what the strengths and weaknesses are of whistleblowing practices in the NHS.

3.1 Methodology

The sampling design was a combination of convenience, maximum variation, and purposive sampling techniques. This was to ensure our interview sample included various roles within the process of raising a concern, and to ensure the sample wasn't biased towards a specific type of Trust.

First, a call for participants was made through the Freedom to Speak Up website (freedomtospeakup.org.uk) which allowed people to put themselves forward to participate in the research. The call was open to everyone working in the NHS, i.e. those working both in Trusts and in primary care. The call was administered by Mencap, independently from the Review Team. The call was open from 20 July-15 August 2014. There were 29 respondents to this call. From these 22 participants were selected based on their role in the whistleblowing process, and the type of Trust they worked in.

A second call was then made by Mencap, targeting HR managers and Directors from the 30 Trusts selected for the policy review. This resulted in 9 additional participants.

Finally, we completed our sample composition through snowballing 11 additional participants.

In total we selected 42 participants, and 5 withdrew before the interview took place. This resulted in the following sample:

Role in whistleblowing	n=37
People who had raised a concern	14
HR managers or Directors	11
Other managers or Directors	4
Others: - regulator case handlers - independent case handlers - union experts - support organisation members - coaching experts - solicitors	2 1 1 1 2 1

Table 1. Composition of interview sample (role in whistleblowing)

Our sample included participants working in acute trusts, mental health trusts, ambulance trusts, community providers, and GP practices.

We conducted 37 semi-structured interviews between 4 September and 31 October. Our research design was inductive. Interview questions were deduced from theoretical perspectives[8] developed to gain insight into operational aspects of internal whistleblowing. We asked questions around:

- perceptions of attitudes, organisational norms, and competencies towards taking concerns seriously,

- perceptions of effectiveness of internal whistleblowing (rather than the fear- factor) as research suggests this is the more important determinant,

- operational challenges such as: aims and indicators of whistleblowing policies, triage and investigation of concerns.

With whistleblowers we started the interview from their personal experience. With managers and Directors we started talking about their policies. With other interviewees our question were phrased as around their area of expertise.

Interviews took place face-to-face or via telephone (because of time restraints). Place of interviews was at the participant's choice. This was mostly in the interviewee's private sphere (frontline staff, and others) or at the workplace (HR managers and Directors). Interviews were carried out during September and October 2014. Interview duration was between 30-90 minutes. All interviews were audio recorded with the participant's permission. These were transcribed verbatim and anonymised by the University of Greenwich research team. Anonymised transcripts were emailed to the interviewees for approval or amendment. Amended and approved transcripts were used for analysis.

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8   Vandekerckhove, W., Brown, AJ and Tsahuridu, E. (2014). 'Managerial responsiveness to whistleblowing: Expanding the research horizon', in AJ Brown, R.E. Moberly, D. Lewis and W. Vandekerckhove (eds) *International Handbook on Whistleblowing Research*, Cheltenham, Edward Elgar, 298-329.
        Brown, AJ, Meyer, D.P., Wheeler, C. and Zuckerman, J. (2014). 'Whistleblower support in practice: Towards an integrated research model', in AJ Brown, R.E. Moberly, D. Lewis and W. Vandekerckhove (eds) *International Handbook on Whistleblowing Research*, Cheltenham, Edward Elgar, 457-495.

This research was approved by the University of Greenwich Research Ethics Committee (UREC 13.5.5.9). We worked under strict confidentiality. At no point was the identity of the participant or the Trust they worked for disclosed outside of the University of Greenwich research team.

Transcripts were thematically analysed using a paper based process. A subset of 6 transcripts was analysed by both University of Greenwich researchers. This resulted in 34 themes. These were compiled into 28 themes, and subsequently grouped into 8 overarching themes relating to elements of the whistleblowing process. Each of the researchers then analysed half of the transcripts.

3.2 Findings

We present the findings according to how a whistleblowing process may unfold, starting with overall perceptions of whistleblowing, followed by raising a concern and then responding to concerns. An important point stemming from the policy analysis related to ways in which organisations monitor the whistleblowing policy. Hence we grouped some of the findings around that. Finally, since any whistleblowing process happens in the context of organisational cultures, we group findings on specific cultures under the theme NHS culture.

3.2.1 Perceptions of whistleblowing

There is no univocal perception of whistleblowing. Some of our interviewees (HR managers and Medical Directors) did acknowledge that in general people do raise concerns out of a professional ethos. A number of them did however find some negative aspects salient enough to make a point. A HR Director said:

> "I have seen very clear examples where people have used the whistleblowing process to support their grievance, or support the issue they particularly have with the trust. And I've seen that not just in the NHS. […] And that's one of the hard things I think about whistleblowing, is to maintain that purity of the thing, because people look at it cynically sometimes I think." (#23)

This seems to be a worry many HR managers have. They acknowledge the usefulness and necessity of whistleblowing procedures but fear that these will lose their distinctive character. A Director of Workforce said:

> "Having worked at a range of NHS organisations, it does worry me that the word whistleblowing these days seems to be a catch-all for anything, or it can be used as a catch-all. Personally, I have to say, I think that's quite dangerous because I think it devalues where there are true whistleblowing cases. […] I'm not even sure that the word is the right word anymore, because I think it means very different things to people obviously since Mid Staffs and things like that. […] I think the danger is that the real true cases of where people have got real genuine concerns and can't get them heard, which absolutely there needs to be a mechanism. I think they get phased out by the people who say, 'Well actually I'm not happy with the pay grade I'm on and therefore I'm a whistleblower' For me, that's something that we've got to be very careful about as we go to the next stage in how we're going to address this." (#26)

However, there are other voices as well. One HR Director was more relaxed about the so-called misuse of whistleblower protection, and saw it as part of a process towards a more mature organisational culture in the sense that people in the organisation have learned to cope with different ways in which a particular process can start off or can take a turn. He said:

> "[People] are more aware of the concept of whistleblowing, and I think that they're aware of the fact that it brings - if you are a whistleblower there's a level of protection that you're entitled to. I think some people are using that in an inappropriate way, but it is what it is. Again it's part of the journey that we're on,

and we'll pass through that. So I'm not overly concerned, but it does sometimes complicate processes." (#18)

Most of the frontline staff we interviewed had personal experience of whistleblowing that had resulted in reprisals against them. Their view was that these reprisals had a very discouraging effect on others. A Quality Manager who had previously blow the whistle told us:

> "And so what happened is people either leave and find another job somewhere else because they witness how people are treated. And so they say well I'm not going to raise the issue about her because I'll be the next person in the restructure to lose my job. People who've got young children and mortgages, they can't afford that risk." (#19)

Another frontline staff interviewee told us how difficult it can be for people to raise a concern despite poster campaigns:

> "I just worry that we focus so much on … it's a bit like focusing on complaints. […] But complaints aren't the problem, complaints are the people who feel resilient enough to be able to put a complaint forward. The people you need to worry about are all the people who never make it that far, who will just sit there and accept whatever crap it is that we're throwing at them. And I feel the same about whistleblowing; you have to be really, really pushed into a hole before you even consider doing something official. And the ones we need to worry about is everything else that's going on." (#01)

A manager from an ambulance service acknowledged that when staff do not raise their concern inside the organisation, this is an indicator of the general level of trust:

> "Too often people will prefer to make anonymous allegation in the press – rather than raise anything formally, here. I guess that says something about the perception that individuals have – that, rightly or wrongly, they're frightened to raise concerns […]" (#31)

This resonates with what a regulator case handler told us:

> "Sometimes they send us emails through the enquiries box. That goes through administration and then CQC. And some may call. So they are on the phone and anonymous in that way. Other times they submit, you know, the form through the website. Good number of those, especially lower grade stuff. So, lower B and D tend to come through website or email through anonymously." (#03)

An interviewee from the support category acknowledged that raising a concern can be responded to swiftly and appropriately with the person raising the concern remaining free from any detriment. However, this interviewee emphasised that if the first response goes wrong, the risks to the person raising the concern are very real:

> "it's not that every doctor who raises a concern but every doctor who raises a concern that's challenged or not responded to, they are then at risk." (#32)

A coaching expert held a similar view. This interviewee acknowledged that raising a concern often is unproblematic, but also pointed out that:

> "[T]here's a modus operandi which means that you raise concerns about something that someone doesn't want to hear and they start to suggest that you've got performance issues, when they've never suggested it before. So all of a sudden HR is involved, [...] deciding to performance manage you because you're raising concerns about something they don't want to hear about. So there isn't any independence at that point. Then you raise concerns more formally, but you're already considered to be a troublemaker because someone's trying to make you look that way."

A theme that is present at all the stages of the whistleblowing process is the entanglement of grievances and whistleblowing concerns. The stories we heard from whistleblowing frontline staff included instances where although their concern included patient risk they were advised to raise a grievance, but also where other staff were pressured to raise grievances against them after they had raised their concern at several levels in the organisation. Some of them suggested these were deliberate manipulations by management. In other stories the concern became entangled with grievances when people raised a grievance for reprisals they experienced after raising a concern. It is important to point out that in the latter scenario people were actually complying with the strict separation of grievance and whistleblowing concern. It seems that as the whistleblowing process drags on, this entanglement is unavoidable. As one HR Director puts it:

> "[Sometimes] somebody does try and raise a concern which is seen as a small concern, and then the way that's handled, because it's frequently handled badly, things then escalate. People don't feel they're being listened to. So they might find other reasons to complain, because they're still striving to bring everybody's attention back to that initial point. So then they raise lots and lots of concerns." (#25)

We also heard a very different appreciation of escalation in the context of whistleblowing. One case-handler said:

> "people get overly identified with their own responsibility to follow the thing through to the ultimate end. [...] If she'd taken a different fork in the road and said this isn't a matter of a criminal burden of proof, this is a matter of a contractual issue, yeah, she could have parked it with the medical director with a clear conscience and just said ... or with the finance director with a clear conscience and said 'Look, here's all of my evidence, ok, you're being fleeced' [...] She could have squared it with her conscience, I have done my duty you know" (#06)

This perception of whistleblowers as people who desperately keep on raising a concern resonated with perceptions held by other interviewees who experience whistleblowing from a different perspective. Whistleblowing frontline staff acknowledged it, as their stories were an account of how things escalated when they raised their concern again and again. But they only did so because they never saw other responses than denial. Our interviewees also gave indications that often people only realise that what they are doing is whistleblowing because of those denying responses and escalating reprisals. Thus, it is often in a context of grievances or grievance-like situations that one realises specific reprisal is happening:

> "[The] terminology 'whistleblower' wasn't there at the outset when I was informed there was a review of my post. I knew why it was going on but I didn't actually link the word whistleblower with what was happening to me. I found out that they wanted to get rid of me because of the stance I'd taken. Because I'd briefed them and I kept on and on and on to senior management within the Trust and then it

clicked to me that that is whistleblowing. And then when I contacted the solicitors it was as clear as daylight that you'd had that meeting, you'd had that meeting and had that meeting, this is whistleblowing in a serious way. So I think it was after the event or during the event that I realised whistleblowing was taking place and that's why they wanted to get rid of me." (#14)

"I've become aware that there are a good number of us that are unknowingly inadvertently whistleblowers and those that are knowing. There are many employees that raise concerns in the workplace either verbally or in writing and aren't quite aware of what they've done or the potential repercussions of being targeted for it." (#05)

Some management interviewees gave examples of people continuing to raise their concern with the press even after investigations had not found any substance to their concern. This suggests that responding to concerns can be just as difficult as raising them, and they require equal attention and effort. However, as mentioned earlier, it is definitely not the case that all managers we spoke to thought a clear distinction between grievances and whistleblowing concerns was possible or even needed. A number of management interviewees perceived whistleblowing as a way to signal organisational problems that might as well have been raised or expressed in a different way. A Director of Corporate Affairs said:

"Well actually, there's more than one way to skin a cat, if you like. As I said before, providing people a - bringing these things out in the open, it doesn't really matter what channel they go through particularly." (#21)

A Director of Workforce said:

"I see it as a sort of spectrum, and I think people have commented before that whistleblowing is one end of the spectrum and raising just general issues may not be so serious, but it creates a culture of openness where concerns can be raised at the earliest possible opportunity is not whistleblowing but actually it's a long spectrum." (#28)

There were a number of voices across the different interviewee categories that explicitly framed whistleblowing in a very broad context of organisational culture and engagement. A Director of Workforce said: "we need to row back from whistleblowing and actually build it into our whole engagement process." (#28), which resonated very well with what another HR Director said: "you would hope, wouldn't you, with a higher level of engagement, a lower level of people feeling the need to use the whistleblowing policy, or they can't come forward with issues." (#23)

Whistleblower interviewees also expressed their frustration with how unresponsive and engagement-averse cultures had driven them to where they were. A solicitor described the problematic narrow view on whistleblowing as follows:

"I think there's a degree which - was it the Head of NHS England or the Head of the CQC said recently when he was talking about whistleblowing, and he was alternating between the definition of a protected disclosure in the Employment Rights Act and the phrase 'whistleblowing' as if they were interchangeable, but they're not. They're two completely different things. A whistleblowing is expressing concern; a protected disclosure is a category of whistleblowing that reaches legal barriers and passes certain tests. I think the approach that's often taken is 'person A has raised some concerns; is it a protected disclosure? Not yet. Then we don't need to worry about it.' And again, I think that comes from this thing of seeing it as a litigation

risk/HR issue rather than saying, 'How do we look into these concerns without having to escalate things?'" (#33)

It seems plausible to assume that the design and implementation of internal whistleblowing policies was triggered by the implementation of PIDA into the Employment Act. An interviewee from a support organisation suggested that the framing of whistleblowing as an employment issue not only has an effect on how organisations deal with it internally but also how unions approach it. Further implications of this particular emphasis arise when one seeks to use the legislation:

"The judge in the Tribunals are not really, panels do not really grasp the seriousness. So, if I say to them 'This has a serious impact. Patients were harmed', they are not experts to interpret that. They don't know how significant that protected disclosure is to the health and safety of patients. They are not really interested in that, they are just thinking 'Well, does this fit the criteria on the protected disclosure?'" (#02)

3.2.2 Raising a Concern

It was clear from the interviewees across the categories that raising a concern starts off informally. Managers expressed this as an employee preference, for example:

> "People may not want to use the formal procedure and I feel actually that's increasing, people not wanting to use the formal procedure but instead come and talk to somebody in confidence – particularly that's one of the executive directors or non-executive directors." (#28)

This HR Director explained this preference for informally raising a concern by making a reference to perceived problems with more formal whistleblowing.

> "[They] don't want to use something as formal as whistleblowing because perhaps it has a very negative connotation too, both in terms of process – in the media, you see that people feel victimised when they raise matters in that way." (#28)

An exception to this might be ambulance services, where a manager told us staff concerns are most often raised anonymously.

> "[P]eople send the complaints from anonymous email addresses. They'll create a fictitious email address and send it via that route – and that is becoming increasingly common." (#31)

However, interviewees also mentioned problems with informally raising concerns. One problem is that only people who are confident enough will also raise it informally at a higher level. As one HR Director told us:

> "[My] experience is people have just come to the office and knocked on the door and ask to speak to either the Director of Nursing or myself or the Medical Director. They just go to somebody they trust and start talking to them. And I generally know the people who are confident to do that." (#30)

This resonates with what a whistleblower interviewee told us:

> "But a lot of people won't dare to do it. And whereas when people are raising issues and just being cut dead, they're taking it as oh well maybe it's not my place and they've not got the confidence to go back and do it again. But I do keep going back and doing it again. [...] I tried all the right channels and then thought oh you know what, sod it and just went to the top and spoke to the chief execs." (#11)

Frontline staff interviewees with whistleblowing experience confirm that people start raising their concern informally, but in contrast to manager interviewees they did not see this as a preference or perceived this helpful.

> "Before I sent that letter, I had lots of meetings with managers about things that we could potentially do to improve the service." (#09)

> "Me being ignored by the ward manager was the final stray and I put a complaint together, a letter together and I've basically raised ..." (#11)

> "I raised my concern verbally with the head of division, three times, but I didn't invoke the Trust Whistleblowing Policy at that stage. And I didn't know about or mention the PIDA at that stage. But I did go to her verbally with quite some

> significant concerns, what was effectively undermined by her, to the extent that I did not feel like I could go back again." (#42)

This doesn't have to be a problem, as indeed raising a concern formally is only necessary when the informal route is unsuccessful. However, for a number of interviewees it was the preceding informal stage that caused problems for them later on.

> "Because if you cause trouble and you whistleblow and you whistleblow informally and they don't work and you have to take a formal grievance out, then you're punished. And this was quite for me ... it was almost like her last bit of power on me." (#19)

Another interviewee told us that after raising her concern verbally three times with the Head of Division, she went to the Deputy Divisional Director who told her to put it in writing so the Trust could act on it. Our interviewee however opted not to do this until a year later, when her concerns still had not been acted on. A couple of months after she raised the concern formally there is a meeting. "And at that meeting, the Head of HR tried to get me to take out a grievance against one of my colleagues. Basically, tried to get me to minimise it to an individual issue between myself and another doctor, which isn't the case at all." (#42)

The interview with a solicitor confirmed that the move from raising concerns informally to formal whistleblowing is often problematic:

> "More often than not, people will first of all raise it with their colleagues and say, 'Hang on, what do you think about this? We've got untrained staff doing this,' that and the other, or 'We don't have enough nurses,' or 'We've got a consultant who's having to do a clinic who's turned up to a clinic session where he's been effectively on call for 48 hours beforehand'. I think things of that nature, they'll discuss with colleagues and then they'll often try to feed it up the chain to management, nothing is done, and then there's this decision to say, 'I need someone to take notice of me here. I'm going to do this formally in writing.' And that's the stage where if it's going to go wrong, it goes wrong." (#33)

Another problem with whistleblowing procedures a number of managers told us, is that they are not often used.

> "We have a whistleblowing line which is hardly ever if ever used." (#18)

> "Formally there's a whistleblowing helpline but we wouldn't get any response. I don't know of any statistics we get back from that to say people have used it. I certainly haven't seen any if we've got any. I think it really is a difficult area." (#20)

If these procedures are used, they are also sidestepped and concerns are raised externally.

> "We do have a small number of concerns that are raised through that process. Having said that, we've also, across the last three years - not huge numbers, but across the last three years- we've had two issues of concern that have been escalated directly to the CQC. The question in my mind about those is why did they take that route rather than the internal route?" (#26)

> "Concerns have been raised within [this Trust] primarily in two ways: one is at local level with line managers or others and resolved informally, and the other way has been to go external to regulators such as CQC. Now that's a more recent feature. So

> involving the formal policy has never really featured at all in this organisation apart from - since I've been in post - one or two times." (#21)

It seems that whistleblowers do not necessarily decide to do this rashly. Rather, raising a concern externally is considered when they have given up hope that the organization is able or willing to correct the malpractice.

> "If my story was to get out, particularly because it concerns babies, it's emotive. I believe it will attract national media attention, and that again, has put a huge pressure on me to try and maintain confidence of the organisation, to some extent in the hope that they will be able to sort this out. But also, I don't want to create mass panic in the local population. I don't think that will be helpful. What I want is for the organisation to get some decent policies in place, get some decent leadership and management in place, and provide some decent training once they've done those things." (#42)

However, trying to raise the concern externally is not always successful, as this whistleblower account reveals:

> "We even stuck our neck out and reported ourselves to the Counter Fraud Squad, because of the claiming that he'd done inappropriately when we found out when they came to audit us. We even stuck our neck our as a practice to say 'Please come in.' The Counter Fraud Squad now say that they can't investigate unless it's paid for by the local CCG, and the CCG say 'That's too expensive to pay for, so no, that's not going ahead'." (#10)

Across the different interviewee categories we heard various ways in which people raise their concern. Using the whistleblowing procedure is certainly not the first port of call. Rather, people resort to the whistleblowing procedure because they've repeatedly entered their concern through the incident reporting system (Datix) or tried to raise it informally. Although it might be a fair point for managers to say that whistleblowing procedures are used for inappropriate concerns, it might equally be useful to wonder whether the other, more appropriate channels are as effective as they could be.

On the other hand, whistleblowing procedures would also be invoked for inappropriate types of concerns that include an issue of power. From the management side we heard that people did not have a problem to raise issues that are "very directly patient-facing" (#30) but there is much more hesitation when any kind of issues arises where someone having power over them is involved. One example a frontline interviewee gave was this:

> "It's ridiculous, the people we're supposed to go to for comments about our training, our training programme directors, they're also the consultants we work with on a daily basis. So how can you possibly go to somebody and say 'Do you know what, I was completely unsupervised last night when you were on call'? Because then you have to go back and work with them the next week and the week after and the week after, you're not going to do that." (#01)

Our non-whistleblower interviewees fell into two groups, with one holding on to the idea of gatekeeping the formal boundaries of whistleblowing procedures, and another group opting for a more broad and fluid approach. A case handler saw it as follows:

> "This is about the separating out of concerns about care malpractice or wrongdoing at work from personal grievance disputes. To me that's absolutely key to it, that's crucial." (#06)

And a HR Director told us:

> "So we have to be quite clear and go back to them and say to them 'There is a time and place to raise these issues. It's not through the whistleblowing policy. It's not through these general culture conversations with a whole range of people. It's with your line manager or with your line manager's manager.' There are some people who use those processes to pursue personal issues, so it's for us to be clear about what each of those separate processes are for, which is not for progressing personal grievances. We have other policies to deal with that, grievances, harassment, etc." (#24)

There seem to be a number of problems with that gatekeeping approach. One problem is obviously knowledge of the procedures. Whilst managers would tell us that the procedure is on the intranet, whistleblowers would tell us that they had come across the policy on the intranet when they were already experiencing reprisal or repeatedly being ignored, and were looking for other ways to escalate their concern. A whistleblower told us that you would get a hypothetical scenario at the job interview but there was no training on the policy or on what concern should be raised through which procedure.

> "I cannot remember at any time of any induction in any organisation anyone talking about raising issues of concern certainly. But I think pretty much universally every job interview I've ever done for a job in the NHS a question of that type has come up." (#09)

A HR manager acknowledged that it takes quite a bit of effort to get people to know the specific aims of a whistleblowing policy before they would need it.

> "We've always had a process for raising concerns in the Trust, always. We've always had a policy, always had a kind of reporting process, a kind of concerns reporting process. But then when you ask people, 'Well why didn't you raise this as a concern?' - 'Well, I didn't know how to.' Ok, well, tell you what, leave you with no doubt, ok. If anyone comes to me now and says 'I didn't know how to raise a concern at all', then I don't believe them. I really don't. Because this is everywhere. We put this everywhere. And I think that's kind of what you have to do sometimes." (#23)

We also heard accounts from people who did follow a policy or professional guidelines to the letter, and were disappointed to find out reality doesn't match the letter of the policy.

> "I've just followed exactly what my Royal College says you're supposed to do and all these things to letter pretty much in terms of who you speak to, who you speak to next, how you document it and blah-blah-blah. I think the problem is that there's a massive difference between what people write in advice from Royal Colleges or the GMC, between what people ask at interview questions for consultation interviews or registrar interviews you know […] I don't think people ever actually do this stuff and maybe that has been my mistake." (#09)

As a whistleblower suggest, an effect of a gatekeeping approach to whistleblowing might very well be that people in general and specifically when they raise concerns, will also develop a very formal approach.

> "They will vary evidence that is enlightening and damaging to them and will pull in any information that's hearsay, heavily opinionated to be put against the employee to say there is no case, you're being vexatious or this or that. So teaching an employee how to evidence their submissions, teaching them how to sign for receipts for submissions, having it in writing what your contents of information submitted. It's basic investigation tools that need to be taught to the whistleblower to give them any chance of being safeguarded against targeting." (#05)

The upshot of that might very well be more whistleblowing directly to the regulator, or anonymously in the press or social media, leaving organisations unable to correct malpractice quickly and effectively. A Director of Workforce was facing that problem at the time of the interview:

> "People can sometimes make statements in the public domain, which we can't actually properly deal with. We're saying 'what are the issues? Help us to understand them. If there are issues around patients, we need to know what they are' - so that's where we've struggled in that." (#20)

There are however also a number of Trusts that have recently stepped away from a gatekeeping approach and have started to develop a more broad and inclusive perspective on raising concerns. These Trusts are experimenting with channels that are far less rigorous procedurally but aim at increasing communication and engagement throughout the organisation.

> "We looked at our policy, probably about 12 months ago, 18 months ago, because when we looked at it we thought it didn't really do what we wanted it to do. It was a bit too procedural and it didn't really give that emphasis to really encouraging people to speak up. So we tried to change that focus and at various points we've communicated and re-communicated the processes and the channels that are open to people if they have concerns." (#18, Director HROD)

> "All that does is pull it all together and provide a channel directly to the Chief Executive, which has always been there anyway under the policy, but it just makes it simpler for staff to get their head around, rather than going 'I'm worried about X, Y or Z. Which of these policies applies?' Because it's a bit dark in there. It's a bit hard, isn't it, for people at times. So it's just simplified and crystallised things really." (#21, Director Corporate Affairs)

> "I think one of the issues that we have identified in the past is that perhaps there have been too many ways, and it can be a little bit confusing to staff." (#26, HR Director)

> "I don't think any policy on its own would work. It's got to be broad enough. Where I am at the moment, we are currently reviewing it. Because it can't just be a policy, it's got to be a range of other, what I would call organisational development interventions that have to be put in place. [...] Because you can have a policy that says 'If you have a concern, raise it in this way' but if staff don't feel safe to raise a concern, it doesn't matter what the policy says, they're not going to use it. Or what happens is they go elsewhere to raise the concern, outside the organisation potentially. Or it's done anonymously and it's very difficult to handle and manage that. So you have to create a culture where people feel safe to raise concerns." (#25, Director of Resources)

> "[People] absolutely need to be in an environment where they feel if they've got issues, they've got concerns as professionals, or as general employees, that they can

raise that issue immediately. I don't think you can have an organisation with an engaged workforce where people don't feel they are able to come forward and challenge and ask questions." (#23, HR Manager)

In responding to our questions relating to different ways people raise a concern, a number of interviewees mentioned the role of the unions in the whistleblowing process. Our interviewees were not very positive about raising a concern with unions. Some whistleblowers and also an interviewee with considerable experience as a union rep told us that for unions whistleblowing cases are too risky to take up because their outcome is too uncertain and they require a lot of resources. Another aspect that does not speak in favour of the role unions currently play in taking up staff concerns is that they tend to only look at them as an employment issue. An interviewee from a whistleblower support group also pointed out that Royal Colleges on the other hand would only focus on best practice. The whistleblower who might be at risk of having an employment issue because of raising a concern about malpractice, is thus left without support that has expertise in the dynamics of being at risk of employment issues due to best practice aspirations.

> "By the time they get up to a senior person in the union, the whistleblowers are way-way down the line here, and their concern has been changed into an employment dispute. […] And then what we are finding there is that the unions are offering easy exit routes for the whistleblowers to leave the organisation and not actually challenging the organisation. […] Certainly, the Royal Colleges do best practice, you know, that they are Royal Colleges of Surgeons, of Physicians, of Nursing. They are there to promote patients' safety and best practice. But they are not actually challenging these organisations." (#02)

A whistleblower interviewee said of unions:

> "I feel very, very sorry for people who go to their unions thinking that they're going to get defended for a whistleblowing case because they won't." (#05)

A HR Director similarly suggests that union reps are not really interested in being 'whistleblower reps' but prefer a less formal – and less resourceful – role. However, this interviewee also goes some way in acknowledging unions are not a first port of call.

> "Sometimes they do raise the issues with the trade unions. Not always. Sometimes they'll go directly to one of the disclosure officers that are listen in the policy or a senior disclosure officer and go straight to them. But there have been examples in the past where people have asked if they can speak with me, for example, with their trade union rep in support of them. So I've met with them and with the trade union rep as well. It's just taken up, and I think the majority would come through directly or seem to come through directly to a disclosure officer. At one stage, we did have staff reps as disclosure officers, but actually on reflection, we felt that that wasn't the best use of Staff-Side time. They felt that they would prefer to be there as an informal point of contact to support somebody, rather than someone who's managing the process with a person raising a concern. So we did change that in the policy but they use both routes." (#24)

The external channel most often mentioned in interviews across our four categories was the CQC. It seems to be impossible to discuss the dynamics of raising a concern in NHS organisations without also discussing the role the CQC plays. As one interviewee told us:

> "[W]hen the CQC get involved, everyone takes note. They absolutely don't want a bad report from the CQC. And when the CQC comes in everyone runs around making sure everything is hunky-dory. They don't want anyone getting the CQC involved because they know the CQC have independent powers and they cannot influence them, whereas if anything that's internal they are in the control of the outcome of. Do you see what I mean?" (#35)

We found quite some confirmation of this in the interviews with managers.

> "We've had CQC and Monitor visit us recently because, there have been issues raised with them about people being able to raise concerns in the organisation. We had both CQC and Monitor here to do what they call a preparatory review. Clearly they've had information which suggests to them there was a need to undertake that review." (#20)

A number of them admitted rethinking their approach to raising concerns internally because staff had gone to CQC, and the way the CQC had reacted on those whistleblower concerns. A Director of Corporate Affairs said:

> "So I would say we've really ramped this up in the last 12 months, and that's partly due to some of the experiences that we've had around the whistleblowing agenda really partly to do with, we did see a sort of rise in individuals going externally to CQC as a first port of call, not really talking to anybody internally in a couple of cases. [...] "I wouldn't rule out that ever happening again, but there's been a marked — since we introduced that campaign, it's dropped right off. The only time I've had contact from CQC about concerns since May has been with patients' complainants predominantly." (#21)

A HR manager told us that apart from people going directly to CQC, the awareness that this is a viable route has also meant people would raise their concern not immediately but definitely before using a formal whistleblowing procedure.

> "[One] of the features which seems to come through a bit more now is that people don't get what they want then the next place to go is to the CQC or more to the CQC than through the whistleblowing policy. Because I think some of the issues have got wooden stance scrutiny via the whistleblowing policy, whereas the CQC are obliged to just take it on face value, I think."

A regulator case handler did not acknowledge this trend but saw it as a spectrum.

> "Some come to us because they're dissatisfied with the response they've had from the Trust. Some come to us because they don't have faith in their managers to address it robustly, and some come because they can raise concerns with us anonymously, and they feel more secure in doing that." (#36)

Another regulator case handler emphasised the importance of people raising their concern with them for their role as a regulator.

> "It is absolutely priceless to have the whistleblowing information in terms of being able to target your time and energy. And also when we get whistleblowers it does say a thing about the Trust and why these people are sharing information with us and they can't share with the Trust. So, it is always important and useful to hear specifically from whistleblowers." (#03)

Although this interviewee mentioned that there are individuals who also seek psychological and legal support through the CQC, in general people see the CQC as a recipient of information in an attempt to relieve themselves of the burden.

> "In most cases the whistleblowers don't want that much contact with you. Cause you represent sort of a reminder of the stressful circumstances they are in." (#03)

The interviewee also alluded to the advantage of being a regulator without a mandate for employment issues, namely not having to worry about motivation or the grievance dimension of a situation, but merely focusing on the alleged malpractice.

> "What was interesting to me, cause the consultant surgeon went first, and we met separately, the feedback from the consultant surgeon was quite dismissive. So, it said like 'Oh yes, it's just another surgeon wanting, you know, more money, or more staff'. So he was focused on the motivations. Whereas because I am trained as a regulator, I know that it does not matter. I don't care about the motivation. What matters to me is the facts and the impact." (#03)

3.2.3 Type of concerns

In the interviews we did a whole spectrum of malpractice that people raised a concern about, was mentioned. These included very specific and identified wrongdoing such as financial irregularities related to change projects or non-transparent allocation of resources. There were also breaches of the law.

> "It frightened the hell out of the patients to be detained and restrained by security staff. It looked terrible to members of the public and it looked terrible to those other patients who were 'compos mentis' and knew what was going on, it looked shocking. And as far as I was aware it was also illegal because I'd been trained in the Capacity Act, I understood the Mental Capacity Act, I understood mental health and these people were not being assessed." (#14)

Other concerns were much broader and did not include identifiable breaches of law but were nevertheless concerns about malpractice. Two interviewees had tried to illustrate their general concern with accounts of concrete behaviours. But both had experienced this meant their concern had not been taken seriously.

> "I wrote a letter to the CEO and copied it to the Chair of the Board and the Medical Director, raising my concerns about these kind of management issues. But also touching on clinical issues as well because I'd learnt up to that point that if I only talked to people about management issues, they all said 'Well, does it really have any effect on people? You're raising concern about financing or organisation of the service but does that really matter?' So I tried to kind of negate that argument in advance by also giving illustrations of where clinical care substandard as well. In retrospect, that was possibly an error to do that because what happened was in my letter to the Board I raised I think it was 10 or 11 points. What happened was that the Trust focused entirely on the clinical points and portrayed it as me being critical of my colleagues. And sought to very much isolate me from my colleagues and from everybody really. So it's a very difficult one because if I hadn't raised the clinical points everyone would have just ignored my letter, but because I raised the clinical points it gave them an avenue simply to pick on those things and to use that as a kind of wedge. And still to date they've never actually addressed and no-one will discuss the elephant in the room which is the financial background to the whole thing." (#09)

> "It's like they don't care whether or not it's staffed properly and efficiently and they don't see it because they're just seeing the tick boxes. And it's just destroying the whole morale. And there must be … I bet there's a thousand examples that people can just reel off with it all but nobody feels that any of those little examples are important enough to be an actual complaint. I've put them all together because it's the attitude. […] I'm finding it quite difficult because I'm raising the concern of the attitude of middle management. And to explain somebody's attitude in a list of 'for example', reading it back when its words sounds like I'm in a playground and I'm saying 'She did this and she didn't …' so that's been quite difficult. Because it is, it's an attitude, it's culture; it's the whole attitude and culture on raising the issue with what I call middle management." (#11)

A frontline staff interviewee suggested that if you only look at concerns that are raised through the formal whistleblowing channel, you are missing the reality of genuine concerns.

> "If you get to the point of whistleblowing, you've already gone too far. And you're only getting the tip of the iceberg of what actually happens on the ground level. So most of the concerns that we raise as juniors on a day-to-day basis, that's not whistleblowing. We've never even considered that they were properly raising concerns, we're saying that there's a problem here and that gets stuck at consultant level or middle management level or somewhere else." (#01)

A HR manager who had stepped away from the gatekeeping around the whistleblowing procedure and was developing a broader approach to raising concerns confirmed that this had led to an increase in 'small issues' of concerns being raised. This manager linked this to a decrease in people raising concern with the regulator, which confirms that what management sees as 'small issues' are indeed genuine and real concerns for staff.

> "We're seeing a lot more concerns being raised through [our campaign], although not major issues. It tends to be quite small issues. And we haven't had any individuals going to CQC or any of the bodies since we put [our campaign] in." (#23)

A considerable number of interviewees across the categories mentioned bullying. Some told us that what they were raising concern about was a bullying culture. We will return to the theme of 'culture' further on in this report, but it is important to mention here that sometimes the bullying itself was the concern, whereas other interviewees gave an account of how a bullying culture was precisely what was blocking their concern about breaches of hospital policies from being perceived as credible concerns by senior management. Other interviewees characterised non-responsive cultures as fundamentally bullying cultures. A number of managers with gatekeeping attitudes towards whistleblowing felt frustrated that people used the whistleblowing policy to raise a concern about bullying, which in their view was a grievance issue. However, what other interviewees said suggests that people might be pushed to raise concerns about bullying through whistleblowing channels because they do not perceive other channels as effective.

A regulator case handler said the following to that effect:

> "When people get to a point where they are, become more a whistleblower, they are stressed and vulnerable and pressurised by the system. And for whatever reason they don't feel able to share their concerns through what would be considered the normal route. Most often the people who don't feel they can are people who are being disciplined or people who are being bullied or at risk of discipline. So there are obvious motivations to include self-preservation. And for them, clarifying their concerns and refining them to that sort of coherence which fits the legislation, it's not something they are trained to do. When they are that vulnerable and emotional, you know, it's very hard for anyone, really. So they do tend to be quite emotive concerns." (#03)

A whistleblower interviewee expressed it as follows:

> "Protected patient care, you need protected employees. You attack employees, you attack patient care; it's the basics, which is why some of the things I whistle blew, like the right to verbatim records for investigations, loads of different angles with educating employees, to correct internal process, they don't want that" (#05)

A Director of Corporate Affairs also acknowledged that a strictly legal definition of whistleblowing can fail to appreciate the genuineness of a concern.

"I think what there was — in essence what the issue was their perception was that because of the organisational change that was happening, morale was low, lots of staff were off sick. This then was a causal factor leading to concealed operations, people feeling under pressure. The ultimate consequences of some of that could have been risk to patient safety, was the way it was framed. […] They were saying that because we had a high level of sickness, there were unqualified staff supporting operations, which I didn't seem to find evidence for. […] So it was kind of channeling into, 'Actually this is a risk to patient safety', although there was nothing tangible. There were no clinical indents they could point to. But I absolutely get where they were coming from in terms of, if you've got people feeling that way in a really high risk environment like an operating theatre with vulnerable patients, then yes you can see that picture building up.' (#21)

A solicitor expressed a similar line of reasoning:

"The protected disclosure doesn't come out of the ether. Usually it's clinicians who see that there's a problem, and it may not be something - more often than not we're not talking about individual events or surgeons where surgery goes wrong and a patient is injured in a surgery. It's more often than not, in my experience, organisational problems, very often related to funding and staffing and resources and things like that, which then has knock-on effects which means that the service that's being provided to services as patients or whatever they may be, is risky." (#33)

The notion of 'good faith' or the motivation of the whistleblower was mentioned a couple of times. Although there seems to be consensus that good faith is important, there was also consensus that a 'good faith test' is not helpful.

A Director of Corporate Affairs said:

"[…] the changes in PIDA around the kind of good faith element. I don't really get that. I think good faith has to be an element of raising a concern." (#21)

A case handler told us:

"[It] has to be in good faith. But they've parked that at the remedy stage, they don't say that you have to demonstrate good faith because God, who could do that?" (#06)

A union expert was of the view that a most helpful approach is to assume good faith:

"What should happen is HR should say we regard every person who raises a concern that isn't dealt with properly a risk to the Trust. That's how we're going to define the problem. And because it's a risk to the Trust we will make sure, we will give people the benefit of the doubt, we will not introduce some stupid good faith test, we will assume that everybody is raising them in good faith, we accept that there may occasionally be people who aren't but we will welcome them, treat them in good faith, we will investigate them quickly and properly. If there's something in it we will act upon it and we will let people know we've acted upon it. If we don't think there's something in it we will explain why and we will do so within a quick timetable. And what's the problem with doing that?" (#32)

3.2.4 Responding to concerns

There was evidence in the interviews that managers are starting to realize that responding to concerns not only entails considering appropriate action but also giving the person who raised the concern an answer.

A union expert phrased it as follows:

> "And the only real issue is we've got to make sure we get back better to people who raise concerns." (#32)

This seems almost trivial, but it was remarkable how poorly established these feedback practices were. For example this is what two Directors of HR and a case handler told us.

> "Well to be fair when we talked to our unions, the big thing we missed out last time was about giving feedback to individuals. [...] It didn't actually figure into the previous policy to give feedback. So now at least we do give the feedback." (#30)

> "They do flag things. They get an acknowledgement, and they know it's being taken forward. What I think we don't do so well, and what comes back to us, is we don't give detailed feedback as well as we might, and I think that's a gap for us if I'm honest." (#26)

> "[The] problem is that they will perceive that somebody has tried to shut them up or that you know, there's a whitewash going on. I think you do need to actually have some mechanism for feedback." (#06)

Indeed, there is of course no such thing as not responding. Whistleblower interviewees often expressed having met denial, but they certainly did read a response into that.

> "[He] obtained that [external] advice, it was given to the Trust in January but they disagreed with this advice and they ignored it. They even suggested that the barrister had been wrongly briefed. [...] We were also seen as challenging the status quo and rocking the boat as well. 'Who are these ... oh they're nobody, they're just two security managers who know naff all, they don't understand the complexities of delivering medical care, so they know nothing and they don't know what they're talking about, so we'll just treat them like we do everybody else. We know best and we're not interested'. So again nothing really happened." (#04)

> "... and then the fact that they denied that I'd done whistleblowing. What had I done then? It was whistleblowing. It was about patient safety because this was a person that was Head of Quality and Patient Safety." (#19)

> "We had a very frustrating 12 months where nothing really happened and they just kept going round ... you know, it's like form a committee, talk about, so don't have to make a decision or do anything about it." (#04)

In some instances, attempts were made to normalize the practices people were raising a concern about.

> "And so I shared with her some concerns that I had and she agreed, she said yeah it's just the way it is. But said that the message she's getting is that people should be glad to have a job." (#07)

> "So if they know there's a problem, then what's the point of saying anything? I think that's how I feel is that you get to a point where you've said ok, so I've spoken to my

consultant, I've spoken to my supervisors, I've raised this from a [...] training perspective and 'Yeah we know we're short', 'Yeah ok, we know that doesn't happen', 'We know that's not good'. And ... ? And it's never an official recognition that things aren't right either, it's always a ... you know, you're never going to get an email from somebody saying 'Thank you for raising X, Y and Z, we appreciate there are problems.' You always get a word in the corridor going 'Yeah, I know it's not right. It's ok, we know it's busy out there'. Yeah, exactly." (#01)

At other times, people who raised a concern were explicitly told off.

"The Director of Nursing who's very senior, this is an executive member of the board, she ignored me. Unless I'd hit her over the head with a hammer she wasn't going to listen to me. She one day said to me 'I'm not going to get involved in any issue with you and your manager just because you don't get on with her. You can be very challenging.' Now I was the Quality and Patient Safety Manager, you would jolly well expect me to be a challenging person." (#19)

"So the bad attitude of me going with my issue with the transgender patient and being brushed to one side as though I wasn't important, it wasn't important, 'Don't bring it to my door', sort of 'What are you telling me for?' In a community hospital you do that to your five staff nurses over a course of a week, you've only got another five, so you've just took the morale out of 50% of your workforce." (#11)

There were also examples of explicit threats made towards those who raised a concern.

"The official email response back from the head of school, the guy who oversees all my training, was 'If you wish to make "allegations"', and they were in speech marks in his email, 'about your training, then you will have to be prepared to have your conduct investigated'. And I emailed him back and said 'I'm not making allegations, I'm just trying to give you same feedback about the training that's available'." (#01)

"What concerns me slightly more is the fact that they tried to stop me pursuing this you know, they said to me 'Would you like to retract what you've said? You do realise if you continue down this course there may be consequences for you? By the way, this isn't a threat', which I feel was a particularly nice bit to add in. And then I said to them 'Well I don't really understand what you mean by that; what do you mean by consequences? I'm raising a concern in good faith, I believe what I'm saying to be true. As far as I understood everything that means there shouldn't be any consequences for me?'" (#09)

One interviewee also mentioned how one of their peers did not want to side with him raising the concern. Our interviewee had fairly recently joined the organisation and their peer had been there for 20 years.

"[...] if you start looking at the Royal College and GMC guidance on this, well actually if you know that there is a deficit in your service, if you know that resources should be there and aren't, you have a duty to say this because that's to the detriment of your patient's care. So I think unfortunately for him, I put him in a horrible position really and his choice in how to deal with that was just to disagree with what I'd said. [...] And I can appreciate for him that was a very kind of psychologically difficult place to be really, he really either kind of had to say well I've done the wrong thing for 15 or 20 years or I haven't." (#09)

There were also examples of deliberately non-defensive attitudes.

> "The minute somebody raises a concern doesn't mean that that person wants to, say, enter into litigation. And there are times – I'm sure you have, we're all only human – when you have got something wrong and I've had to go and say, 'Look I'm sorry' [...] people seem the think that's a sign of weakness, I don't think it's a sign of weakness I think it's a sign of integrity." (#36, regulator)

> "I take it as a sort of compliment that people feel that they can raise things because I do get a lot of issues like that [people offloading responsibility], and so people obviously don't feel inhibited in doing it, but do I feel threatened at times? Probably yes. But that's just part of my job, and I know that comes with the territory, that someone has to assume responsibility when people raise concerns." (#39, Clinical Director)

Most of the whistleblowers we spoke to had not received any support from anyone in their organisation. For one interviewee this had come as a surprise because the interviewee had previously been off sick for a long period and had received excellent support then, like a regular phone call during sickness and a well-planned re-induction. For the interviewee it seemed like different departments were handling different situations in terms of support.

Another interviewee told us the only useful support they had had was legal support and a psychiatrist who himself had experience as a whistleblower.

One Director of Workforce described the lack of support for people who raise a concern as follows:

> "It's a bit like when somebody puts a bullying or harassment claim in. You always feel the person that's put the claim in, you put your support around the person that the allegations are against as opposed to the person putting the claim in. For me it's the same process, they should both get support wrapped around them to help them through the process by which you prove or otherwise that there's an issue or not." (#41)

A difficulty perceived across interviewees that played a role as recipients of concerns – i.e. managers, case handlers, regulators – was that giving a whistleblower a response to their concern does not guarantee a sense of 'closure' for the whistleblower.

> "They probably won't believe that you've investigated something and you're satisfied there was nothing there." (#23, HR manager)

> "Sometimes people feel, I think, they're passed around the system, but it's because they haven't come into the system at the right portal of entry." (#36, regulator case handler)

> "Now the difficulty sometimes is where those conversations go stale. [...] So I haven't yet had a response from that individual, but the subtext of the message was very clear that if I - he's put his GMC number on things - if I don't respond to that and basically give him a full operating theatre, if anything goes wrong it's my responsibility. And I accept that responsibility, I just need to know. I've obviously got an issue with balancing resources against capacity, so I have to make an assessment with colleagues whether it's a reasonable request to go into a full operating theatre, or whether a procedural room is ok. So that's a fairly sort of live example of the kind of issues that you deal with." (#39, Clinical Director)

Our interviewees gave examples of how a lack of closure often means the person will try to raise their concern somewhere else, although the previous recipient feels the answer already given should suffice.

> "We are seeing people threatening the organisation with going to the CQC when they're effectively not winning the argument." (#23, HR manager)

> "An example at the moment is one of our anaesthetists feels that anaesthesia isn't given enough prominence in the hospital. And that's a really broad concept, and in personal discussions, and in written responses to that individual, I've both tried to address the concerns and responded. But even so, there is still a perception on that individual's part that they've still not got special prominence. So that's gone up through the escalation methodology." (#39, Clinical Director)

One regulator case handler acknowledged that some people who raise a concern with a regulator might end up disappointed.

> "One of the things that's important for people to understand is our role and remit, and what we will do and what our powers are. Sometimes I think there's a misunderstanding of what our role and our powers are, and I think whistleblowers sometimes can be disappointed if they think we should be doing something different […] Or I've met with people and explain what we're going to do, and then they say, 'Well I think those people should be sacked,' and I say, 'Well that's not my decision to make'. So I think what I would like to see is a better understanding of our role but I still want people to feel comfortable and confident enough to come to us with any concerns as well." (#36)

A number of explanations were mentioned as to why whistleblowers might not get closure when their concern is responded to. One of these is that of 'selective reading'. This was mentioned by case handlers.

> "And sometime you'll raise a concern and people will say to us, 'They didn't listen,' and you look into it and say, 'Yes they did listen but you just didn't get the answer that you wanted but they gave you a good, well-considered response'." (#36, regulator case handler)

> "And he says when he won the employment tribunal case which said yes you did suffer a detriment for bringing protected disclosures and he said 'I realised I hadn't done anything wrong so I was obviously happy that the courts found the same'. Well it will probably be no surprise to you that the courts didn't find the same at all (laughs)." (#06, independent case handler)

Managers on the other hand gave an explanation that was related to lack of time. One HR manager pointed out that raising a concern at Board level will take longer than to get a response than raising the concern lower in the organisational hierarchy.

> "If we always bypass the management level, then you just end up all — and that's why it takes a long time to respond sometimes. You said something to the chair, but he's only in once a week. He's not going to get to it quickly, so I always encourage people to go and say 'Have you talked with your manager?' If they say Well actually I don't want to because that person is part of the problem,' fine." (#23)

A Director of Workforce saw a similar time problem also with middle management.

> "I think time is a massive factor. This is what I'm told. I'm not saying I accept that, I have to say. But this is what our middle managers and line managers all say to us - that time is the biggest factor. I also think there's an element, although a much smaller element of, if the response isn't actually what the individual wanted to hear, they haven't necessarily heard anything. So there is something about that. I don't really know how you get around that one actually, because you can keep saying 'Yes but we've told you. We've told you. We've told you.' And if an individual, for whatever reason, doesn't accept that, then it becomes a little bit of a nebulous argument. I do think there's an element of that, but much smaller than time." (#26)

There is however some acknowledgement that more attentiveness is needed in giving the person who raises a concern an adequate response.

> "There was definitely a genuine concern but there was nothing in it in the end. But I think other people might … depending on who the person is raising it, might instantly jumpy to oh it's just trouble-causing, trying to make life difficult […] and I think that's probably more based on the person who's raising it than the content of the issue they're raising." (#30, Director of HR)

> "The issues that were raised to the CQC I think some of those were cynical. I think one of them was a cry for help, and I think we should have listened to that cry for help before the point we got to." (#23, HR manager)

A Director of HR gave an example of how much attentiveness and time might actually be required. She gives an account of physically sitting down with the person who raised a concern, face-to-face.

> "But he thought we were fiddling our waiting list figures because he was in clinic and the consultant was putting his outpatient appointment on and his theatre appointment on and is wasn't coming up … the date was outside of the 18-weeks and it didn't flag it up. And this individual was adamant that we were fiddling the figures. And so what we did … and we kind of almost turned this round within the space of a day kind of thing and it's not normal for me to get involved in patient things but I was senior director on the day. So we immediately looked into it and we checked it out and we have two different systems that responds to this. […] we were looking at the theatre system and the theatre system is not the system which tracks the RTT, it's the patient tracker which does that. […] But we had to sit down with him and explain it to him. […] And the Medical Director ended up explaining it to him. […] We were a bit nervous that he would take the issue and try to make something out of it. But you know, he asked questions and we talked about it and he was absolutely satisfied then. But we physically showed him the patient system and the two different systems. So I think it is about giving that feedback. I mean we have had nurses who've raised issues and you get some quite strong nurses who come and raise an issue but again the Director of Nursing's response was 'Well that's not actually what's happened'. But we will physically sit down and say 'Look, we're going to tell you …' And I think I've had a couple of letters come via me and we've looked into them and again we've brought them in and said 'Look, we're going to explain to you why what you think is the case isn't the case' and they've been happy with that. […] So it has to be that level of feedback." (#30)

Other examples of how to achieve this closure include involving the person who raised the concern in finding and implementing solutions.

> " [...] whistleblowers or people who raise concerns, where many of them want to maintain anonymity, but sometimes when they don't and they're willing to stick their neck out and actually say who they are and be involved, it's useful to involve them, I think, in some of the solutions, being part of the team that's put together to resolve some of the more complex issues. [...] they might not want to take it up. But I think it's good to offer them the opportunity because they felt sufficiently passionate about it to raise it. They're often likely to want to use that energy to support this not happening again, or resolving it." (#24, Director HROD)

> "An example of where somebody has blown the whistle whilst they were employed with us - and didn't get the outcome they wanted. They subsequently retired, and actually raised a concern with Monitor. It came back through to the organisation from Monitor, and we looked at the issue and felt that there was a concern. We actually called the individual back in and said, 'This is what we've done as a result of it' - and she was satisfied with that as an outcome. So I think there are examples of where things have gone well, where things have not gone so well." (#20, Director of Workforce)

Achieving closure might also be achieved by not only responding to the person who raised a concern, but making this response visible to all within the organisation.

A union expert suggested promoting a safe culture in a very material way by promoting those who raise concerns and sanctioning those who retaliate against them.

"I don't know of any whistleblowers who've been promoted. I don't know of ... well I'm sure there have been one or two. I don't know of anybody who has been disciplined for victimising a whistleblower." (#32)

A Director of Corporate Affairs showed us a recent initiative the Trust had started for channeling concerns. Concern of with a personal content dimension would be responded to privately, but other concerns were posted and responded to on the intranet, so that all would be informed, and would also see that the channel actually works when you raise a concern.

> "I could show you if you wanted to see it. It's there on the intranet. They can be anonymous. So some of them, there is a response that's posted on the intranet, so their concern is outlined, and then an appropriate clinician or manager does a written response. [...] Obviously the ones that are personal to some individuals, the CEO does respond to them. So the CEO responds personally. The response may not come directly from her in terms of her knowledge, if you like, but she'll request 'This issue has been raised. The appropriate person is asked to look into it' feeds back the response to the CEO about what is being done about things. They're all action-oriented, if you like. Then the response is given back. There is a process that is followed so loops aren't left open." (#21)

3.2.5 Investigating concerns

A solicitor with experience in handling whistleblowing cases across different sectors told us that in general, where whistleblowing goes wrong in the NHS, this is because of a lack of independent investigation and protective measures for whistleblowers.

> "One of the areas that we work in as a department, quite extensively is in financial services - I mean, a whistleblowing is made in Financial Services, they're terrified. They want to make the whistleblower as happy as possible because the last thing that they want to do is to have somebody that moves on some place else, knowing that there is a - publicity, I suppose, is what they're frightened of. I think in local government as well, there's also a good bit more […] there's a proper investigatory process that goes on. There's much more protection, proper protection, for the whistleblower themselves so that they've got an avenue to talk to senior management, bypassing their line management but also have some kind of assurance that there's a proper investigation going on. They're not left in the same department as they've observed wrongdoing going on because obviously that opens up the scope for them to be subjected to detriment. And these are all thing that don't happen in the NHS." (#33)

An account by a whistleblower interviewee confirms this lack of independent investigation.

> "Because I've been on sick leave, they keep trying to address my sick leave and the employment aspect, and they're not addressing the whistleblowing stuff. I've asked repeatedly for the employment side to be managed completely separately from the whistleblowing, and that just hasn't happened at all. It was very, very frustrating and it went on for months." (#42)

Our solicitor interviewee attributes this lack of independent investigation to the fact that in the NHS, whistleblowing procedures tend to fall under the responsibility of HR.

> "I've got a consultant who's having a terrible time down there in the hospital, I think they're actually trying to do the best they can, and this is not litigious. But there is no policy and so the consultant raises the issue and HR say to her, 'You need to raise a grievance,' and she said, 'I don't want to raise a grievance. This is not about me. I'm not particularly happy with how I've been treated but this is not an employment issue. This is not a HR issue. This is a clinical issue and I want this dealt with by clinicians.' Clinicians just look at each other and say, 'It's a HR issue.' So the whole thing falls down in the middle. I think HR probably do the best that they can but there is no real understanding of what it is that motivates whistleblowers to blow the whistle." (#33)

Nevertheless, it was a Director of Workforce who insisted objectivity is needed when handling whistleblowing: "Whistleblowing isn't about keeping everybody happy – it's about getting to the facts, isn't it." (#28) And again in the context of not getting sidetracked by the mix of grievance-like and public interest concerns: "I think that that can be resolved by looking at how those types of issues are investigated and creating elements of independence." (#28)

From the accounts given by our whistleblower interviewees, it became clear that more objectivity or independence would increase the likelihood of successful whistleblowing but also that of achieving closure for the whistleblower. For example:

> " [What] they did do is they organised an external review of our service but they were very clear that it was not being done in response to my concerns. In fact they were absolutely crystal clear about that because I asked them about five times. And they also refused to do it through the proper mechanism for doing it because the Royal College has an invited reviews mechanism and they refused. I said 'Well can we do it through the invited reviews mechanism?' and they said 'No, that's too formal, we'll arrange an informal external review and we'll get a surgeon from another unit to come and have a look round and see what he says'. And clearly the reason it was not done in response to the concerns I'd raised, even though clearly it was, was because that allowed them to get their external reviewer only to look at the clinical aspects of the service but not to look at any of the management or financial stuff that I'd highlighted." (#09)

Maintaining this objectivity remains tricky, even for a regulator. Although their processes are designed to safeguard independence, there are many variables that can make an investigation harder to do. An example mentioned as exceptional by a regulator case handler gives us the required configuration.

> "So it was, you know, in a nice tiny bowl the perfect example of what an ideal whistleblowing case would look like. Person very openly shares the evidence we need. Not so emotive about it. So, this is the experience, it is not right. The Trust is not doing anything about it. So, they come to us after going to the Trust. And we were able to take quite quick action about, a very specific action." (#03)

An independent case handler gave a counter-example, indicating how complex cases can be.

> "Because if somebody says 'I'm not going to operate on this patient because I don't have the gold standard equipment' and the other guy is saying 'You're cancelling patients because you don't have the gold standard, you're not doing anything for them because you haven't got the best, you're not giving them any service.' [...] if this all goes nasty you know (laughs), who's the whistleblower? [...] You know, it's not always clear. And you have to try and unravel some of this stuff." (#06)

A HR Director on the other hand, gave an example of how HR actually can provide the objectivity of taking a concern at face value.

> "[Because] I'm HR so I don't know the detail about those systems. And the fact that it came to me, I immediately took that very seriously (laughs). Now if that had gone straight to the Director of Ops, she might have instantly thought oh this is a bloody waste of time because she knew instantly that he was wrong. [...] So sometimes it's probably helpful for somebody who's not so closely involved in it to address it or perhaps to have two people addressing it." (#30)

Given that this HR Director more or less acknowledges the serendipity of handling this particular concern in an appropriate way, we need to ask what the role of HR is when people raise a concern. The views of our interviewees tended to suggest this should be a limited one. Our solicitor interviewee insisted whistleblowing is a clinical rather than a HR issue.

> "My view on this is that whistleblowing is not and never has been a HR issue. I think the mistake that is made is to treat this as a HR problem, and very often HR see whistleblowing as a procedure that sits on the same shelf as the grievance procedure, the disciplinary procedure, the capability procedure, and they're all just ways and means of managing staff. But that's not what whistleblowing is. […] [It's] a clinical care issue, more often than not, in the NHS. It's a clinical issue, it's not a HR issue. The only time that HR should get involved is where you're talking about the role of management or if you're talking about specific bullying and detriment that somebody has brought up as a result of whistleblowing, but it's not - whistleblowing is not about the whistleblower, it's not about the individual. The individual is no more than a witness to what's join on."

A salient turn in rationale by a Director of Workforce gives some ground to the suggestion to limit HR's role. This interviewee discussed at length has reporting near-misses needed to increase now that incident reporting was at an appropriate level in the Trust, both processes not administered by HR, but then insists that "if it was whistleblowing, then that will be dealt with through another process. It's usually through HR in terms of raising that concern." (#41)

A Director of Resources argued that HR's role should take care of the people management dimension of raising a concern, seeing it as an indicator of culture or specific group dynamics rather than an employment issue.

> "[There] is a danger that HR can just believe what the manager tells them, or believes what the employee tells them. And actually, they have a role in bringing objectivity, and asking some of the 'why' questions. Why has this person raised this concern? Why hasn't it been able to be dealt with by the manager? Why isn't the individual satisfied with the response? Why does the manager think that response is acceptable? Asking the 'why' questions in a very independent, objective way - and almost acting as mediator or translator, sometimes, between the employee and the manager. Because my observation, again, often what gets in the way is language and interpretation." (#25)

A coaching expert suggested that an external element to an investigation is a stronger guarantee for independence, objectivity, and due process.

> "No one was really taking much notice that the policy wasn't used but concerns were raised openly. They basically set up a biased investigation investigating what went on, but actually involving some of the people who had completely ignored the concerns that were being raised in the first place. There wasn't any independence about it, it wasn't impartial. So organisations are not necessarily the best people to investigate their own problems, quite frankly." (#35)

It would be trivial to say that confidentiality is key to due process in handling or investigating concerns about workplace malpractice. Nevertheless, more than one whistleblower interviewee mentioned issues with that. One whistleblower gave an example where confidentiality was not built into the process in a GMC investigation.

> "You couldn't freely give your own personal thoughts, because you were constantly thinking 'What am I saying? He'll hear this. […] What we didn't know was that any comments he had to make about it would not be given to us, so it was completely one-way process. […] They told us afterwards. I asked if we could have the comments given to us, and they said no, we would have to request it under the FOI Act. But when I have, they say it's unlawful." (#10)

Two regulator case handlers did however describe better confidentiality provisions in the process through which the CQC operates.

> "We review the information usually within 48 hours. This is a specific process in CQC, where a team of people in our contact centre specifically established to manage whistlebowing cases tracks it. […] If we need to share information, we have to think carefully about that. Normally we prefer if the whistleblower leaves their name and contact details because we can facilitate that in a safer way. But sometimes they don't, and we need to share information let's says with the police or Safeguarding Authority directly. So, we will do that in the first instance and then the information will be used to plan an inspection along with lots of other information." (#03)

> "I think our inspection process helps shine a mirror on the culture in the Trust. I think – but it's new. It's our new approach, and it's only been in place for just over a year, but we're starting to see some positive results around culture and openness and candour, and of course the new fundamental standards around duty of candour are helping. People are having to consider it an a way they didn't before." (#36)

3.2.6 Monitoring policy

Only one interviewee mentioned a Trust that had half of a whistleblowing policy. The others had a policy and some had even very recently rewritten their policy. But when we asked our manager interviewees how the policy was monitored, none had a well defined set of indicators.

One of the reasons is that as we mentioned earlier on, maintaining a strict legalistic definition of whistleblowing in an organisation misses out on what could escalate into an ET battle. As a Director of Workforce explains:

> "Formally there's a whistleblowing helpline but we wouldn't get any response. I don't know of any statistics we get back from that to say people have used it. I certainly haven't seen any if we've got any. I think it really is a difficult area. [...] The whole thing with, you've got a concern, you've got people seeing and saying something, or suggesting an improvement. That's a whole continuum. It's very hard to monitor, because you can monitor the number of whistleblowing concerns through the procedure. But actually what you really want to make sure is that everything is taken up, so that all goes well."

A number of Trusts had started to triangulate data not only for the purpose of reporting to the Board, but they would also triangulate data on a specific ward or department whenever a concerns was raised about a malpractice in that ward.

> "I've had a debate, actually, over the last couple of weeks with our Audit Committee where we report whistleblowing, just to say that we need to triangulate other data so that we get a better picture, because an organisation [this big] and the volume of patients we put through, you might expect more than 12 people raising whistleblowing-type issues in a year." (#28, Director of Workforce)

> "I think it's really important not to just look at what comes through formal policy, I think it is important to triangulate data to say 'What is the health of the organisation?' and where things are raised, where is it they come, that there is an opportunity to try and pool that information together to see if there are a rising tide of issues that are occurring." (#28, Director of Workforce)

> "We do try to triangulate the whole picture. So it may be the complaints are perfect - that there an't any complaints. There are no grievances. Staff aren't raising anything at all. But everything else [number of falls, staffing levels, absence levels] is red, then you have to go in ask the question. That's the way we try to just not take things at face value." (#26, Director of Workforce)

Such a triangulation seems to fit with a broader approach to raising concerns, away from the gatekeeping approach towards whistleblowing. Such a broad approach including triangulation of data has also recently been taken up by the CQC.

> "As part of our new approach, we always have five questions about the service of the Trust. IS it Safe? Is it effective? Is it responsive? Is it caring? And is it well-led? As part of the well-led, we always try to understand and develop a sense around the culture and the management of the organisation. We do this through the methodology and we hold a wide range of focus groups, and peer-led. We have opportunities for staff to come and see us privately, if they so wish. We spend time on the clinical areas of patients and staff to understand their experiences of being treated and working the Trust. We have a range of interview with very, very senior staff. Then we try to

triangulate all of that information, including the intelligence we have – the policy, the procedures – that the Trust share with us, the perceptions of other stakeholders, the CCGs and RCN, and GMC." (#36, regulator case handler)

3.2.7 NHS culture

Our interviewees often made reference to the NHS culture. When questioned how such a huge organisation as the NHS could have one culture, or even how one Trust could have a single culture, they acknowledged there were cultural differences between departments and wards, but nevertheless insisted there was a layer of 'the' NHS culture.

They described this in relation to whistleblowing in a number of ways. One HR manager felt that some well known cases where whistleblowing in the NHS had gone wrong was deterring people from raising a concern.

> "I think that way lies the problems that the NHS have had in the past, to be honest, which is, people end up – because they know what the consequence of coming forward is going to be, so people stopped doing it. And I think that is a cultural thing in the NHS." (#23)

A Director of HROD acknowledged that a HR culture of defensiveness is still not overcome.

> "I think that the NHS culture isn't quite right and I think the whistleblowing cases we've seen are a reflection of that. I think it's something we need to deal with in all our organisations. I suppose I'm talking - I'm an HR director and you have to deal with employment issues, grievances, conduct issues. And I know from talking to HR director colleagues, that there is a level of defensiveness, sometimes, about these issues are not so clear-cut as they are sometimes presented in the media and I think that is true. But I also think there are significant cultural issues that need to be sorted our in organisations and it's not … I think the extent of the number of whistleblowing cases that we've had is a reflection of that." (#18)

A coaching expert made a similar point and referred to an enduring lack of independence of HR.

> "I think the difficulty the NHS Trusts have got is that there's a lack of independent HR advice and support. So basically, if you were going to use - I know raising concerns policies are - you can raise concerns to whoever and the generally make that clear, but essentially you're generally raising concerns to someone in the organisation and so it's quite difficult, because if you were going to raise concerns informally in a healthy organisation, someone would act on it without you having to formally do that. […] I wouldn't necessarily advise people to internally whistle blow, because of the lack of independence and you wouldn't have any knowledge of the kind of politics. You just don't know who's batting in what direction, basically. That's just based on my experience, really." (#35)

A solicitor made a comparison between NHS whistleblowing and whistleblowing in other sectors, and pointed out that what is specifically problematic about NHS practice is suspension.

> "There is another thing that the NHS does to whistleblowers which I've not seen anywhere else, which is that what the NHS do is they will suspend. You blow the whistle; they then instigate some kind of process against you, which is usually ostensibly not to do with the whistleblowing, so it'll either be a disciplinary or it will be a capability procedure. […] They will suspend you, but indefinitely, and you'll stay off for months and in some cases years while an investigation is supposedly going on which never really concludes. What that does is it leaves you in limbo because you cannot speak to your colleagues, you don't know what's going on with the

whistleblowing, and if your job is a clinical job that requires you to undertake CPD, you can't do that, so your profession is at risk. […] You're basically put on ice. And all the while public money's being spent paying your salary even though you're not providing a service, and you could, and that tactic is peculiar to the NHS. Nowhere else that I've come across uses that, and that tactic is used again and again and again, this kind of long term suspension. It's used so often across the country that I cannot believe that these individual HR departments just come up with this themselves, because it is such a standard practice." (#33)

There were however also many instances where differences between NHS cultures were mentioned. An HR Director of an ambulance service said:

"I think having worked in an acute hospital as well, what I would say is that the culture within the ambulance service is very, very different. It very much has an industrial feel to it. And you probably don't get the professional representation that maybe you get in a hospital. So it's got a very blue-collar feel to the organisation, very high levels of trade union membership – and very loyal to the trade unions. So in terms of culture, I'd say that it feels entirely different – it's a lot harsher environment than exists in a traditional hospital." (#31)

Most whistleblower interviewees related the problem to a specific to a ward or department. One frontline staff interviewee (#1) contrasted her team to that of another ward, where good leadership allowed people to work as a team and address mistakes directly or question one another. This was in contrast to the interviewee's team where matrons had been coming and going, resulting in an individualistic dynamic that pretty much amounted to a blame culture. Another whistleblower interviewee mentioned that she would put the wrong department on an incident form "just to get it out of the building" (#11). There were also managers making reference to specific wards with issues of bullying where they had to intervene.

Another common theme was that problems often originated or persisted because of middle management. Whistleblower interviewees told us top management had been wrongly briefed by HR of by the Chief Nurse (#04, #07), that top management agrees with them but their manager interferes again and again (#11), or finding that the new CEO was credible but not powerful enough to change middle management's attitude (#09). A point made by a Director of Workforce confirms this.

"Much of the feedback that I receive from staff and their representatives is that staff who have access to the very senior levels of management, usually are fairly comfortable with voicing their concerns and their opinions at that most senior level of management. It tends to be more at the middle level of management where there is a sticking point." (#20)

There were also some references to how racism manifests itself in the context of whistleblowing. A solicitor saw a pattern emerging from the cases they had dealt with.

"I've seen, and I know my colleagues have seen, a large pattern of South Asian origin doctor whistleblowers, because I think there's a different culture. There isn't that collegiate med school, we're all in this together, rugby team mentality that might exist a little bit more with UK-educated doctors, although I may be showing my own prejudice here. Asian doctors - South Asian doctors in particular - can find themselves ostracised very quickly." (#33)

A Medical Director expressed it as follows:

> "If you are a whistleblower and BME it's a double whammy. I can tell you, whistleblowers and BME staff there is a lot of similarities in the way NHS treats them. [... Also,] if a BME raises concerns about white doctors, in some Trusts it is not investigated or it is dealt with informally. In some cases when BME doctors are blame, they are immediately suspended. The BMEs are punished if a white doctor raises a simple concern." (#13)

Many interviewees mentioned bullying in the context of whistleblowing. Some were more specific suggesting there would be a strong correlation between Trusts with a bullying culture and where people get harmed when they raise a concern. As one interviewee puts it:

> "This isn't just about whistleblowing, this is about if you disagree with me and I'm in a position of power, I'm going to treat you so badly that you leave, because it's going to take me so long to use any HR process to get rid of you and prove you to be incompetent." (#35)

When asked what drives this culture, interviewees answered that an old style of leadership and promotion, together with a target driven, fire fighting culture was blocking a more engaging, compassionate, and values driven leadership.

> "What you end up with is a system by which everyone's focused on the numbers and as long as the numbers are ok, that's all that matters. What you end up with is this incorrect reporting. People are just focused on the reporting rather than focusing on what's behind it - what are we actually doing?" (#35, coaching expert)

> "About the NHS, what we need to do, is slow things down to speed them up. We are fire fighting. Daily fire fighting. Everyone needs to stop restructuring the NHS because every time things feel - we never actually see anything through because every time there's a restructure, before you've actually embedded it, someone else has come along, there's been a new political party, and we're constantly restructuring. [...] [T]here's IT systems that are not fit for purpose. All the things that make your job really difficult. The finance processes are really complex. So there's all sorts of things that make the NHS a really stressful place to be because they're called what we call in coaching world, irritations. You've got these constant irritations on a daily basis because you can't get stuff done. But actually, if you slowed it down and stopped putting so much performance on to people - the whole organisation seems to be obsessed with meeting its performance targets when actually, if it just slows down a bit, it would give itself some space to - it just needs to give itself some space really. We're just constantly fire fighting." (#35, coaching expert)

> "I think traditionally, the NHS has valued a type of leadership that's been fast paced, focus on delivery, focus on targets, rewarded achievements on target, and probably the behaviours that have supported target focus. In terms of quick-wins, get the task done, let's tick the box, let's make sure we're meeting all those targets so that we're not subject to some kind of regulatory performance management or any scrutiny. [...] So I do think some of it is about the culture of the NHS as a whole, and not just the culture of individual organisations." (#25, Director of Resources)

3.2.8 Changing culture

Despite the negative references to a persisting NHS-wide culture and the problematic local cultural problems just mentioned, we did come across some examples of promising cultural change. These pockets of learning were however still developing, with new approaches being tried out, experiments with new ways of responding to concerns, and leadership development programmes.

Some of these were externally triggered by the CQC's new approach. As one regulator case handler told us:

> "We've got good evidence now emerging that when we've been inspecting a Trust and we've help the mirror up, and we tell them what we think is wrong, when we've gone back, we've seen measurable improvements, so it does work. [...] But if we go back and they haven't made these improvements then we will escalate to the next enforcement." (#36)

Some interviewees suggested that further regulatory development would be required to harness a more widespread cultural change within the NHS. One HR manager was of the opinion that a regulatory relationship such as exists within the aviation industry would be beneficial. A similar opinion was voiced by a coaching expert who said:

> "[T]he question [...] is can organisations independently regulate their own behaviour? And personally, I don't think they can [...] I think regulation needs to become much more sophisticated because if you've got organisations who are - if they declare that they're not performing and that they can't do whatever's been asked of them, they get vilified and ridiculed and whoever loses their job, so no one - there is a real disincentive for people to be honest about how they're doing." (#35)

The opinion of another Director of Workforce resonates with that.

> "Where the organisation has been on its journey we've been under the spotlight has probably made the organisation less willing to take risks. Risk averse actually to create that culture of learning - continuous learning - you need to take a level of calculated risk. So that's why the board are having this development about what appetite does it really have for risk. And bearing in mind, the whole structure we work in and the politics we work in. The regulatory body does not promote taking a risk, I would say." (#41)

Nevertheless, none of our interviewees had been left unaffected by what happened at Mid-Staffs. One Clinical Director found that this had woken up Trust Boards and had empowered staff.

> "Basically, just remove those feelings that you're causing a problem by raising an incident. It's much more you're solving a problem. [...] I think that culture's been there. [The Francis Report] for me has really raised the Board's consciousness level. It was always there at the clinical business unit level, service level. [It] was clearly viewed that it was a clinical service issue, not something that necessarily the Board needed to really monitor and get on top of. I mean we had policies and things but it's certainly focused people's mind a lot more, at board level. The other thing I think it has done is it has empowered staff. I think that they have read the narrative to come out of Mid Staffs, and have felt that they have a responsibility. So it has

helped in that regards that people have felt they've got a mandate to raise concerns, so that's been really helpful." (#39)

There were also a number of intended or less visible interventions, or at least not immediately visible on the work floor. These internally triggered change processes all seek to embed whistleblowing in a broad culture change encompassing engagement, leadership development, and career management. One Director of Workforce said:

> "Raising just general issues may not be so serious, but it creates a culture of openness where concerns can be raised at the early possible opportunity [; ...] some of it's around training and modifying some of the existing systems and processes we have that take place in advance of whistleblowing, because whistleblowing the end game, really [...] actually what we really ought to be doing is thinking way before we get there, how to create a culture of more openness and safety and people seeing it positively about continuous improvement, continuous learning, but there's some excitement to it rather than some negative connotation to it." (#28)

Another example is from a HR Director of an ambulance service, who found the level of mistrust a barrier.

> "We're doing a lot of work, and have done for the last year and a half – to improve staff engagement across the organisation, and will continue to do so. But that sort of mistrust is certainly a factor, and that's evidenced by our staff surveys." (#31)

A Director of resources described the vastness of the required culture change.

> "So have you got the right recruitment processes in place that recruit the staff with the right values? Have you got the right talent management and succession planning in place to make sure you nurture leaders with the attributes that we're looking for? Have we got a leadership strategy in place? Have we got quality appraisals in place? Everything needs to be aligned. It isn't just one thing. It;s a whole number of things. [...] Because it can't just be a policy, it's got to be a range of other, what I would call organisational development interventions that have to be put in place. [...] Because you can have a policy that says 'If you have a concern, raise it in this way,' but if staff son't feel safe to raise a concern, it doesn't matter what the policy says, they're not going to use it." (#25)

A HR manager described how the Trust intends to implement values driven leadership.

> "I don't think anybody's got a problem with the NHS Constitution Values. But the process - I don't think they were really owned by our staff. [...] From that, we then started to look at what are the behaviours that actually reflect and reinforce those values? And we've tried to build those into our appraisal processes, we've developed a 360 appraisal tool to reflect that. [... Our] aspiration, our intention is that all our band seven staff and above will be required to undertake this 360 appraisal annually as part of their PDR process. And ultimately will start to inform decisions around things like pay progression, but we're not at that point yet." (#18)

It became also clear that if this culture change is going to proceed and succeed, it will have to be visible and will have to affect all levels within the organisation. It was mainly our manager interviewees who acknowledged this.

> "So I think it's the bigger the organisation the harder it is to reinforce things that get normalised as it's not acceptable because I think the Executive Team are so distanced from it." (#30, HR Director)

"There has to be - not blame, but you have to take responsibility. I think what's quite interesting is where the responsibility landed. So there was Board level assumption of responsibility, and all down the level, everyone said 'Yeah, we're all responsible for this.' Then if you look in terms of responsibility, in terms of who lost their jobs, it was at the middle management level." (#39, Clinical Director)

"You try and work with the manager but sometimes, it becomes clear that the actual issue and challenge is the manager." (#41, Director of Workforce)

4. Conclusions

4.1   The analysis of whistleblowing policies revealed a number of problems. Although these problems were not found across the sample, there remains scope for improvement. Hence it is important to list the most important points of attention:

• A considerable number of policies were explicitly inclusive in stipulating who they applied to. A number of policies remained vague or contradictory on this point.

• We saw very good examples where the difference between grievances and wider concerns was explained and contextualised. However a considerable number of policies tended to adopt a very legalistic description of whistleblowing as 'protected disclosures'. This is puzzling, even more so because Trusts do not have to enforce PIDA. In fact, Trusts should understand PIDA stipulations as what they need to cover in their policies as a minimum. Instead, whereas the good faith test was removed from PIDA and a public interest test was added, Trusts seem to have also added a public interest test in their policies without removing the good faith test. The implication of this is that many Trusts have a policy that is more restricted in what it promises to protect than PIDA does.

• A number of policies include wrong or incomplete information about regulators and advisory organisations. Some also use mistaken or incomplete descriptions of confidentiality and anonymity.

• The general trend is that policy encourage raising a concern informally before invoking a formal route. Our interviews indicated that this is a particularly risky moment for raising concerns to deteriorate into reprisal. Some policies allude to a professional duty to raise a concern. Trusts must be aware that emphasising someone has a duty to raise a concern implies a duty on the Trust to ensure it makes it safe and effective to raise a concern. In light of this, it is striking that most policies in our sample used the negative wording that reprisals will not be tolerated. The stronger, positive wording that reprisals will lead to disciplinary action would help in guaranteeing of safe escalation from informal to formal whistleblowing, and towards the implicated duty of the Trust to guarantee safe whistleblowing.

• Training, registering, and monitoring were weak elements across the policies in our sample. It would be useful to link this policy to leadership development programmes such as those that were mentioned in the interviews. Registering and monitoring are areas where practices still need to develop.

• Nearly all the policies in our sample fell under the responsibility of HR. In the interviews however, considerable doubt was raised about the appropriate role of HR in whistleblowing (see 4.4).

• None of the policies in our sample mentioned a role for an external stakeholder such as a regulator or a whistleblower support group in monitoring or reviewing the policy.

4.2   The analysis of the interviews showed a polarising trend on most elements of the whistleblowing process. We conclude from this that within the NHS there are two models emerging of how whistleblowing policies are implemented - without making any claim about the prevalence of any of these two in the total population of NHS Trusts.

- One model entails a gatekeeper approach to whistleblowing procedures. It tends to use a strict legalistic definition, and proponents worry about misuse and mixing up of grievance-like situations with wider concerns. This approach is focused on investigating major wrongdoing only. There is a tendency to attribute responsibility for failed processes on others.

- Another model that is developing takes a broad and engaging approach to whistleblowing. It tends to accept a wider range of concerns as qualifying for the procedure to be invoked, and regards grievance-like situations as indicators of potential malpractice. There is a tendency towards a low level of uncertainty avoidance with regard to raising concerns.

We found that the gatekeeper model encounters a number of problems:

- as the whistleblowing process drags on, per definition wider concerns will become mixed up with grievance-like concerns; hence the gatekeeper model is less likely to succeed in making whistleblowing successful at a later stage in the process,

- knowledge of the policy and procedure is crucial if people are going to use it correctly; however, people tend to only come across the procedure when they identify themselves as a whistleblower, which is when they experience reprisal or meet denial repeatedly,

- a gatekeeper model implies that not only the person raising a concern but also anyone else in the Trust complies with the procedure; whistleblowers repeatedly expressed that they had found a disconnect between the letter of the procedure and reality,

- people raising a concern through a procedure operated from a gatekeeper approach might develop an equally rigorous attitude to raising a concern, insisting on strict due process, distrusting every operational step of the process, and potentially leading to more whistleblowing directly outside of the organisation,

- this approach encourages informal routes to be used but then deals with the concerns in a formal and legalistic way.

The engagement model shows promising development along the following lines:

- it is procedurally less rigorous, and is aimed to be instrumental to increasing the quantity and quality of communication and learning between different layers of the organisation,

- proponents of the engagement model were also the ones who were developing new ways to give people who raise a concern an answer and explanation; they were also the ones who gave examples of how they help getting the person raising the concern to achieve closure, through a non-defensive attitude, inclusively working towards correcting malpractice, or open communication of concern and response,

- engagement models of whistleblowing tend to have a lower threshold, which might make the step from informal to formally raising a concern less risky.

It is important to note that this engagement model was not represented in our sample of whistleblowing policies that we analysed for this research. The polarisation between the gatekeeper and the engagement model emerged from the interview data. We believe this finding has validity because as the quotes in various parts of section three illustrate, this trend is found across the different categories of interviewees.

4.3   Our interviews indicated that in NHS Trusts a very wide spectrum of concerns are raised. Those who expressed views that we characterised here as indicative of the engagement model, seem to have adapted their procedures to a perceived need.

4.4   The questions with regard to the role of HR in administering whistleblowing procedures were salient. There is however no clear finding on this point. Because most policies in our sample operated under the responsibility of HR, we set out to interview a substantial number of HR managers. Thus our sample was not designed for comparative research into which function is best equipped to operate a whistleblowing policy in the NHS. The points raised by our interviewees are nevertheless important and deserve further attention.

4.5   It was clear that unions currently play an unimportant role in the whistleblowing process. Given their presence in the policy as part of the review process and as points of advice for those who want to raise a concern, their role remain potentially important.

4.6   The role the CQC currently plays can hardly be overstated:

• people go to the CQC to raise a concern,

• the CQC takes up concerns and Trusts notice that they react on concerns,

• the CQC triggers change in Trusts with regard to whistleblowing arrangements and policies,

• the CQC's new approach has many elements of the engagement model which, based on our interviews, is emerging in some Trusts, including seeing a broad set of concerns as an indicator of possible malpractice, regardless of the grievance-wider concern mix,

• there are expectations towards the CQC to develop more of a learning partner role.

4.7   Monitoring the whistleblowing policy is an underdeveloped practice. There are some experiments with triangulation of existing data and configurations of indicators. There is however no consensus on what a good configuration would look like. It is even safe to say that on that aspect there isn't even any contestation yet.

5. Considerations

The emerging engagement model on whistleblowing shows promising developments that avoid many of the problems of the gatekeeper model. However, these developments are in an experimental phase. Other HR managers acknowledged the need for change but didn't seem to have any idea how to action this. In order to improve working and learning cultures within the NHS it is important that further development of this engagement model for raising and responding to concerns is supported and disseminated across the NHS. Hence, based on conclusions 4.2 and 4.3 we ask the Review to consider the following:

- **Consideration 1**
  Develop and validate visible aspects of raising and responding to concerns along the engagement model.

- **Consideration 2**
  Integrate the engagement model for raising and responding to concerns into leadership development programmes in a way that embeds this approach to concerns into notions of the learning organisation, staff engagement, anti-bullying, improving patient care, compassion, and career development.

The whistleblowing policies we analysed showed a huge variation, and did not meet standards of good practice on important aspects (conclusion 4.1). Furthermore, none of the policies in our sample represented the engagement model (conclusion 4.2). Hence we ask the Review to consider the following:

- **Consideration 3**
  Develop a more unified whistleblowing policy across the NHS that meets standards of good practice.
  A suggested approach is to integrate learning from engagement type of approaches to raising and responding to concerns, with input from the CQC and other stakeholders to contextualise the Code of Practice from the Whistleblowing Commission.

There are salient changes to the roles of and expectations towards HR, unions, CQC, and other stakeholders with regard to key functions in the process of raising and responding to concerns. Hence based on conclusions 4.4-4.7 we ask the Review to consider the following:

- **Consideration 4**
  Develop and validate configurations of indicators for monitoring the effectiveness of raising and responding to concerns.
  This will include methods to monitor the prevalence of channels used to raise and respond to various types of concerns, and the methods to prioritise and enquire into concerns.

- **Consideration 5**
  Undertake research to optimise the roles of and relations between various players in the whistleblowing process, in particular HR and CQC.