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Speaking up: a professional imperative

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Safeguarding patients is a professional responsibility. Perioperative staff must take account of their sphere of practice and influence and must report when either care or the environment falls short and patients are at risk of harm, or of a poor quality experience. This will require speaking up and making representation to colleagues and managers. This article explores the distinctions between whistleblowing and speaking up and explores the associated challenges.

Context

When did you or someone in your department last:

- register that patient care was being compromised due unsafe staffing levels or skill mix
- question whether poor patient outcomes were due to a surgeon's lack of capability
- identify that a colleague was on shift, under the influence of alcohol
- report that the WHO Checklist was ticked, but the checks weren't done
- observe poor standards of instrument and swab count?

These scenarios may seem extreme, alternatively they may parallel experiences you have encountered, causing unease and anxiety in the workplace. Beyond registering professional disquiet, it is important that such concerns are properly owned and acted upon and, where necessary, escalated to an appropriate 'authority' for action. In a public service as complex as the NHS, it is inevitable that services, practice and people will be less than optimal from time to time, and will let down patients, families and colleagues. The challenge is to register when things are contrary to best practice, in breach of procedural requirements and regulations, or contravene professional and ethical codes for care.

In some circumstances a concern may surface as a 'hunch' or feeling that things are 'not quite right', or it may be something concrete, observed or experienced. Hunches and feelings should also be attended to, for they are arrived at through the assimilation of objective signs and sub conscious thought processing (Hams 2000). Be sensitive to discomfort in professional practice, for it is an essential step in safeguarding patients. Care giving is complex, physically and mentally demanding and, because many aspects of practice are repetitive and routine, things can go unnoticed (Meurier et al 1997). Cohen et al (1994) acknowledged this and encourage 'presence' when at work, arguing that it enhances our potential to notice. The responsibilities and accountabilities integral to professional codes of conduct require registered staff to notice, and to act as essential barometers of quality, and as patient advocates. Staff are quite literally, the first line of defence and assurance, in a regulated and publically accountable service (HCPC 2012, GMC 2013, NMC 2012). Boddington et al (2002) warned that the strength of such defence is only realised if staff choose to notice and, thereafter, choose to act when what is noticed falls short.

Certain situations will benefit from corroborating misgivings with colleagues, to gain their perspective and possible support. But whether individual or collective, every concern must be grounded in evidence, so that it can be investigated in line with employer and regulator policies (Parker & Lawton 2002).

Practice realities

Evidence suggests (Beckstead 2005) that the likelihood of staff speaking up in a manner that ensures that colleagues, line managers and leaders pay attention, investigate and act upon expressed concerns, is dependent on the organisational culture. Mansbach and Bachner (2010) highlighted that the leadership tone set by senior leaders of an organisation is very important, notably the extent to which they actively encourage constructive challenge and peer review as integral features of individual and team practice. Grube et al (2010) suggested that the likelihood of staff reporting unsafe practice, is dependent on the courage and conviction of individuals to exercise their professional accountability. Equally important is the level of staff confidence in organisational governance processes and the education provided for staff to use safety-critical and risk-focused language. Mansbach et al (2012) added that the likelihood of junior staff and learners speaking out, is entirely dependent on whether the voice and actions of all staff (irrespective of grade) are actively encouraged and valued by the organisation.

Contemporary harm data tells us that speaking up is not exercised nearly enough in NHS facilities (NPSA 2012). If it were, patients would not experience the levels of avoidable harm that they do and we would not observe nearly as many 'work arounds', or deviations from best practice, as are associated with adverse events (Williams & Welby 2012). Further, if constructive challenge were the norm, achieved through peer review and critique, there would be less of a requirement for organisational whistleblowing policies (Firth-Cozens et al 2003).

Disturbingly, while the difficulty of whistleblowing has punctuated the professional press for years it is actually the tip of an iceberg

Whistleblowing

Legally, whistleblowing is defined as a person, usually an employee in a government agency, public, private organisation or company, reporting a concern about mismanagement, corruption, misconduct or some other wrongdoing. The report is made either to the public or to someone in authority outside of the organisational and recognised line management structures (Lewis 2006). However, it is suggested by Jubb (1999) and contemporaries, that this narrow definition encourages an unhelpful focus on the whistleblower's action of dissent (which is often perceived as a lack of loyalty to the organisation), sometimes leading to suspicion of the whistleblower's motives, rather than to due attention of the concern raised.

The professional press contains numerous accounts of health staff who, in highlighting issues of concern were let down, experienced abuse and in some cases were suspended (Patrick 2012). Because the system has failed to support individuals appropriately, whistleblowing has become a perjorative term (Cooke 2012 p 57), resulting in publications such as Private Eye combining satirical humour and investigative journalism, to showcase the hypocrisy (Lockyer 2007).

Codes of professional practice remind staff of their professional and legal duties in civil, criminal and contract law to speak up, yet the conditions that enable them to do so have been found wanting. In 2010 the Social Partnership Forum (SPF), which is comprised of NHS Employers, trade unions, the Department of Health and the independent whistleblowing charity Public Concern at Work, issued new guidance. 'Speaking up for a healthy NHS' (DH 2010) aimed to support employers in devising, implementing and auditing their whistleblowing arrangements. The guidance details what is expected of NHS boards and publicises the support available to staff from an independent telephone helpline run by Public Concern at Work. The guidance subtly distinguishes whistleblowing from speaking up, as a tenet of professionalism and qualifies what employers should do to create supportive open cultures and to ensure that arrangements work locally.

More recently a charter for speaking up was launched (NHS Employers 2012a). It pledged the commitment of the NHS Employers organisation, regulators, professional regulatory bodies, health unions and professional associations, to work more collaboratively in support of staff. The charter signalled how far the NHS still has to travel to affect culture change. But the shift is welcome, for whistleblowing has gained many negative connotations in recent years, which have been to the detriment of speaking up as a fundamental feature of accountability (Peternelj-Taylor 2003). For too many staff, raising a professional concern or constructively challenging a colleague, has become disconnected from professional practice and the daily responsibility owed to patients, with sometimes tragic consequences (Greenberg & Edwards 2009 p158). Such consequences were observed at Mid Staffordshire NHS Trust, Winterbourne View, Maidstone and Tonbridge Wells, when deficits in care of the elderly and vulnerable were not escalated adequately (Cornwell et al 2012).

The trend needs to be reversed to restore patient and public confidence in the professions.

Parapets and punishments

With the introduction of clinical governance, it was suggested that speaking up and whistleblowing would make an important contribution to patient safety (Donaldson 1999). But thirteen years on, despite national and local policies to safeguard patients (DH 2011, CQC 2012), it remains an incredibly difficult thing to do. Data published by the National Patient Safety Agency (NPSA 2012) have always been an indicator of harm versus an absolute figure. While error reporting is improved, figures continue to highlight how few staff, relative to the size of the workforce, report errors or near misses.

Too many patients continue to be failed, because speaking up is often seen as someone else's responsibility. Equally staff can feel silenced by fear of recrimination (Makary et al 2006).

Whether speaking up within line management structures, or whistleblowing outside them, staff have experienced disciplinary and punitive action, loss of employment, have had their professional standing and integrity questioned, and have endured injustices such as being described as mentally unbalanced (Lennane 2012). There is also considerable evidence, particularly in the case of senior leaders and medical staff, that gagging clauses and compromise agreements have been used to keep people quiet, thereby limiting information that should be in the public domain (Costello 2012). Fears for one's employment and livelihood are rightly sobering and understandably create anxiety about 'putting one's head above the parapet'. So it should not be surprising that staff choose to stay 'out of trouble, keeping their concerns to themselves' to the detriment of public safeguards and the public interest. Keeping quiet however, is not without personal risk either, for staff can experience professional and personal torment and emotional and psychological stress in trying to reconcile what they know and their inability to 'out' it (Juthberg et al 2008).

Disturbingly, while the difficulty of whistleblowing has punctuated the professional press for years it is actually the tip of an iceberg, masking the challenges that committed professional staff experience on a day to day basis, as they seek to highlight the indefensible and unacceptable. Challenges such as those highlighted during the testimonies received by the public inquiry into Mid Staffordshire NHS Trust (Campbell 2011) and exposed through the covert surveillance of atrocious care and routine cruelty to residents at Winterbourne View (Flynn 2012).

Where do we go from here?

In March 2012, following calls from the professional regulators and as a result of successful campaigns for whistleblowing protection over a number of years (Patients First 2012), the NHS Constitution was revised, highlighting the importance of staff speaking up and making the responsibilities of employers explicit (DH 2012).
The updated constitution includes:

- an expectation that staff should raise concerns at the earliest opportunity

Speaking up: a professional imperative

Continued

- a pledge that NHS organisations should support staff who raise concerns, ensuring that their concerns are fully investigated and that there is someone independent, outside of their team, for staff to speak to
- clarification of the existing legal right for staff to raise concerns about safety, malpractice or other wrong doing without suffering any detriment.

But change will not happen merely through constitutional change or because of the Speaking up Charter (NHS Employers 2012a). A policy can collect dust on a shelf at St Elsewhere's, just as easily as it can in Whitehall, and a pledge is no more than empty words if it is not brought alive with action. If we seek to improve things both for patients and for those who strive to advocate for them, then we have to work collectively and with commitment, changing individual and collective behaviours. For it is attitudes and behaviours, supported by the vision and actions of leaders, that ultimately shape the tolerances and thresholds for professional practice, quality and probity, and shape the culture of the NHS (Weiner et al 1997).

As an example I can recall being asked to review a whistleblowing policy. The specific invitation for comment concerned the extent to which the policy was 'fit for purpose', robust and in line with national guidance. Not to detract from the genuine endeavour and commitment of the individual requesting this of me, to my mind, they had... slightly missed the point!

Organisations should recognise that whistleblowing is a last resort, something that staff have recourse to only when they feel that all else has failed. The real measure of the openness and transparency of an organisation and its commitment to learn, to improve, to mitigate risk and patient harm, is the extent to which staff and patient concerns are routinely sought, regularly escalated, taken account of and acted upon by managers and leaders.

The universal difficulty experienced by staff has been highlighted in the Annual Staff Surveys of the past two years. Compared to 2010, fewer staff felt able to make suggestions for improvement (69% in 2011 versus 70% in 2010) and less than a third of staff surveyed felt that senior managers acted on feedback from staff. The results also showed a fall in the willingness of staff to act as advocates for their organisation, both as a place to work and as a place to be treated. When asked if their Trust blames or punishes people who are involved in errors, near misses, or incidents, 10% of staff agreed that it did (NHS Employers 2012b).

Avenues and options

For some, whistleblowing has involved working with the media and 'going undercover', as in the case of Margaret Heywood who secretly filmed deficits in care for Panorama. Heywood was struck off the nursing register for breaching patient confidentiality but was later reinstated, due public pressure and a legal case, brought against the NMC by the RCN (Gallagher 2010). Heywood's case illustrates how the 'whistleblower' is as likely to be stigmatised and demonised, as applauded and commended, for taking personal and professional risks to expose unethical practice. Going outside the organisation is usually pursued as a last resort when internal avenues have been exhausted. There are options other than the media, including for example Clinical Comissioning Groups (England), health boards (Wales/Scotland), professional associations such as AfPP, professional regulatory bodies (HCPC/NMC) and public regulators.

Creating the right conditions for staff

The responsibility to embed behaviours that support staff in speaking up, lies at different levels of an organisation. The board needs to make clear that it is committed to developing a just culture and that protecting patients is of paramount importance. Clinical directors and managers need to be supported and trained, so that they fully understand their roles and responsibilities in hearing, responding to and acting upon staff concerns appropriately. Frontline staff need to be guided as to how to gain the attention of their seniors and how to frame concerns objectively and professionally so that they are not perceived as moaning or their concerns as misplaced.

Human resources departments play a vital role in reviewing and improving policies and procedures to ensure that they are workable, and thereafter a role in measuring the incidence of staff reporting and the associated improvements and impact over time. Given the 2011 and 2012 Annual Staff Surveys, further work is needed because, although aware of policies for reporting concerns, staff still lack confidence that their organisation will fully support them if they do (NHS Employers 2012b). Things can and will continue to go wrong in healthcare, because services are delivered by people who are fallible. Celebrating when staff speak up, and potential harm is averted, is incredibly positive and encouraging of others; it is a useful strategy in any organisation (Weiner et al 1997, Benn et al 2009).

Closing the loop

When an incident occurs, or a material failure is noticed, many staff can be relied upon to complete a serious untoward or clinical incident form; however, an equal number of staff fail to do so. While much can be done to improve incident reporting, staff also need to recognise that completing the paperwork is one action within a process and that concerns also need to be voiced, for this is the hallmark of professional accountability and advocacy.

If we get to a point where we need to rely on a whistleblower then we are already in the wrong place. Effective and resilient organisations will welcome staff raising concerns, irrespective of their nature and will see it as a healthy opportunity to learn to improve services and patient experience. Through the work of the Partnership Forum and the charity Pubic Concern at Work, there is increasing recognition that more has to be done to support staff, and that much is dependent upon local NHS champions turning the tide on negative behaviours.

We should be mindful of the insight of philosopher Edmund Burke who said: 'The only thing necessary for the triumph [of evil] is for good men to do nothing' (Burke 1756). Speaking up requires courage and

conviction; it is not done lightly or easily or with impunity (Calkin 2011). Next time you hear someone saying: 'I am concerned, I am worried, this is a safety critical issue', take the time to listen, corroborate the evidence and support them. A parapet is less scary if there is more than one head above it.

References

Beckstead J 2005 Reporting peer wrongdoing in the healthcare profession: the role of incompetence and substance abuse information International Journal of ***Nursing Studies*** 42 325-31

Benn J, Koutantji M, Wallace L et al 2009 Feedback from incident reporting: information and action to improve patient safety ***Quality and Safety in Health Care*** 18 11-21

Boddington R, Arthur H, Cummings D et al 2002 Team resource management and patient safety: A team focused approach to clinical governance ***Quality and Safety in Health Care*** 11 15-18

Burke E 1756 A vindication of natural society: a view of the miseries and evils arising to mankind Available from : http://en.wikiquote.org/wiki/Edmund_Burke#A_Vindication_of_Natural_Society:_A_View_of_the_Miseries_and_Evils_Arising_to_Mankind_.281756.29 [Accessed January 2013]

Calkin S 2011 Whistleblower nurses faced daily personal insults **NursingTimes.net** Available from: www.nursingtimes.net/nursing-practice/clinical-specialisms/management/whistleblower-nurses-faced-daily-personal-insults/5037238.article [Accessed January 2013]

Campbell D 2011 Neglect and indignity: Stafford hospital inquiry damns NHS failings **The Guardian** December 1st Available from: www.guardian.co.uk/society/2011/dec/01/stafford-hospital-inquiry-nhs-failings [Accessed January 2013]

Care Quality Commission 2012 **National standards for safeguarding people** London, CQC Available from: www.cqc.org.uk/public/what-are-standards/safeguarding-people [Accessed January 2013]

Cohen M, Hausner J, Johnson M 1994 Knowledge and presence: accountability as described by nurses and surgical patients ***Journal of Professional Nursing*** 10 (3) 177-85

Cooke H 2012 Changing discourses of blame in nursing and healthcare In: **(Re)Thinking violence in healthcare settings: a critical approach** Holmes D, Rudge T, Perron A UK, Ashgate Publishing

Cornwell J, Pearson K, Martin F et al 2012 Organising the health system to ensure care for the elderly **The Telegraph** Letters to the editor Available from: www.telegraph.co.uk/comment/letters/9168068/Organising-the-health-system-to-ensure-care-for-the-elderly.html [Accessed January 2013]

Costello T 2012 **The NHS whistleblower and the £500,000 'supergag'** Available from: www.thebureauinvestigates.com/2012/06/29/the-nhs-whistleblower-and-the-500000-supergag/ [Accessed January 2013]

Department of Health 2010 **Speak up for a healthy NHS - revised whistleblowing guidance** Available from:www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4050929 [Accessed January 2013]

Department of Health 2011 **Statement of government policy on adult safeguarding** Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748 [Accessed January 2013]

Department of Health 2012 **NHS Constitution updated** Available from: www.dh.gov.uk/health/2012/03/nhs-constitution-updated/ [Accessed January 2013]

Donaldson L 1999 Whistleblowing and clinical governance In: **Whistleblowing: changing the way we work** London, BMA House

Firth-Cozens J, Firth RA, Booth S 2003 Attitudes to and experiences of reporting poor care ***Clinical Governance: An International Journal*** 8 331-6

Flynn M 2012 **Winterbourne view report details assaults and neglect as charities warn it could happen again** Available from: www.huffingtonpost.co.uk/2012/08/07/winterbourne-view-report-details-assaults-neglects-charities-happen-again_n_1750922.html [Accessed January 2013]

Gallagher A 2010 Whistleblowing: what influences nurses' decisions on whether to report poor practice? **NursingTimes.net** Available from: www.nursingtimes.net/nursing-practice-clinical-research/acute-care/whistleblowing-what-influences-nurses-decisions-on-whether-to-report-poor-practice/5010979.article [Accessed January 2013]

General Medical Council 2013 Good Medical Practice [online] Available from: www.gmc-uk.org/GMP_2013.pdf_51447599.pdf [Accessed April 2013]

Greenberg J, Edwards M 2009 **Voices and silence in organisations** Bingley, Emerald Group Publishing Ltd

Grube JA, Piliavin J, WarisseTurner J 2010 The courage of one's conviction: when do nurse practitioners report unsafe practices? ***Health Communication*** 25 (2) 155-64 Available from: www.tandfonline.com/doi/abs/10.1080/10410230903544944 [Accessed January 2013]

Hams S 2002 A gut feeling? Intuition and critical care nursing ***Intensive Critical Care Nursing*** 16 (5) 310-8

Health and Care Professions Council 2012 **Standards of conduct, performance and ethics** Available from: www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/ [Accessed January 2013]

Jubb PB 1999 Whistleblowing a restrictive definition and interpretation ***Journal of Business Ethics*** 21 (1) 77-94

Juthberg C, Eriksson S, Norberg A, Sundin K 2008 Stress of conscience and perceptions of conscience in relation to burnout among care-providers in older people ***Journal of Clinical Nursing*** 17 (4) 1897-1906

Lennane J 2012 What happens to whistleblowers, and why ***Social Medicine*** 6 (4) 249-58

Lewis D 2006 The contents of whistleblowing/confidential reporting procedures in the UK: some lessons from empirical research ***Employee Relations*** 28 (1) 176-86

Lockyer S 2007 A two-pronged attack ? Exploring Private Eye's satirical humour and investigative reporting ***Journalism Studies*** 7 (1) 765-81

Makary M, Sexton JB, Freischlag J et al 2006 Patient safety in surgery ***Annals of Surgery*** 243 (5) 628-35

Mansbach A, Bachner Y 2010 Internal or external whistleblowing: Nurses' willingness to report wrongdoing ***Nursing Ethics*** 17 (4) 483-90

Mansbach A, Ziedenberg H, Bachner Y 2012 Nursing students' willingness to blow the whistle ***Nurse Education Today*** epub ahead of print Available from: www.ncbi.nlm.nih.gov/pubmed/22360912 [Accessed January 2013]

Meurie C, Vincent C, Parmar D 1997 Learning from errors in nursing practice ***Journal of Advanced Nursing*** 26 (1) 111-19

National Patient Safety Agency 2012 **Organisation patient safety incident reports** Available from: www.nrls.npsa.nhs.uk/news-cp/organisation-patient-safety-incident-reports-september-2012/ [Accessed January 2013]

NHS Employers 2012a **The speaking up charter** Available from: www.nhsemployers.org/SiteCollectionDocuments/FINAL%20Speaking%20Up%20Charter.pdf [Accessed January 2013]

NHS Employers 2012b **Annual staff survey 2011** Available from: www.nhsemployers.org/employmentpolicyandpractice/staff-engagement/nhs%20staff%20survey/pages/nhs-staff-survey.aspx [Accessed January 2013]

Nursing and Midwifery Council 2012 **The code: standards of conduct, performance and ethics for nurses and midwives** Available from: www.nmc-uk.org/Publications/Standards/The-code/Introduction/ [Accessed January 2013]

Parker D, Lawton R 2002 Barriers to incident reporting in a healthcare system ***Quality and Safety in Healthcare*** 11 15-18

Patients First 2012 Available from: www.patientsfirst.org.uk/ [Accessed January 2013]

Patrick K 2012 Barriers to whistleblowing in the NHS ***British Medical Journal*** 345 e6840

Peternelj-Taylor C 2003 Whistleblowing and boundary violations: exposing a colleague in the forensic milieu ***Nursing Ethics*** 10 (5) 526-37

Speaking up: a professional imperative

Continued

Weiner B J, Shortell SM, Alexander J 1997 Promoting clinical involvement in hospital quality improvement efforts: the effects of top management, board, and physician leadership ***Health Services Research*** 32 (4) 491-510

Williams D, Welby G 2012 Revealed: extent of harm to patients under NHS care ***Health Service Journal*** 30th August Available from: www.hsj.co.uk/acute-care/revealed-extent-of-harm-to-patients-under-nhs-care/5048798.article?blocktitle=Most-popular&contentID=-1 [Accessed January 2013]

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