I would like to offer a summary of my personal experiences of attempting to whistle blow in the NHS in Scotland and of being victimised for doing so, and my personal views on some of the background issues involved and how they might be addressed in future. I hope these might helpfully address the agenda points in the call for submissions to this inquiry. In my view this saga and its outcome illustrate and highlight many problems with current NHS governance and its managerial and political culture.

Several years ago I raised formally various serious concerns about the safety and quality of a new perinatal mental health service and its management in NHS Lothian. This saga has been widely reported in the media subsequently and is detailed further in supporting documents attached to this submission. I had been recruited to head up this new service from a major centre in England as an established expert in this field with an impeccable career record.

These concerns were never properly or independently investigated, in many instances not investigated at all, and were deferred and then buried until I was forced out of my job. I was initially subject to a widely-publicised ‘gagging clause’ in a settlement agreement ‘offered’ to me. I was subject to demonstrably false allegations about my work, a demonstrably false ‘smear’ campaign, had my specialist career (and a treatment trial for stressed and depressed pregnant women) destroyed, and have effectively been blacklisted in Scotland. The concerns I raised, (although this should not need to be the case), have been vindicated piece-meal by the findings of a few limited inquiries, by a series of critical incidents including maternal deaths, and, recently, by the damning verdict of the Mental Welfare Commission (MWC) on the treatment by NHS Lothian of a woman (Ms OP) with a post-natal psychosis who killed her baby. For the most part the recommendations of such inquiries as did occur have not been implemented. I would be happy to expand on the details of this saga in person if helpful to the committee.

Very recently Paul Gray (CEO of NHS Scotland) recently published a welcome acknowledgement that whistle blowing may be a problem for staff in the NHS. He concluded his piece by urging those whose concerns are not being listened to to come forward and ‘tell him’. As one of the whistle-blowers mentioned, I had in fact done just that and approached Mr Gray formally two years before having fruitlessly exhausted internal procedures, and been victimised for doing so, within NHS Lothian. His response was to refer my concerns back to the very Health Board where I had raised serious concerns about the safety and quality of the new perinatal psychiatry service and its management. This is akin to asking a local police force to investigate a complaint against itself.

NHS Lothian then managed their own ‘external’ review of my saga and its outcomes. The ‘external’ review commissioned by Lothian, at Mr Gray’s instigation, was in fact critical of the set-up and management of the perinatal service and of my treatment, but NHS Lothian refused to publish this citing ‘confidentiality’. I would be astonished if NHS Lothian furnished the MWC inquiry with any of these documents.

I met recently with Paul Gray following his public statement, although only at my insistence and following further media exposure, to present my ongoing concerns. He has since stated publicly on a Radio 4 (File on Four) programme on whistle blowing in the UK (available on-line) that he takes my concerns ‘seriously’ and wishes to obtain my ‘assistance’ in moving forward - although not I suspect in properly investigating my saga, nor wrong-doing and incompetence in NHS Lothian - with its serious implications for safety and quality of services and for managerial culture in the NHS. To have an independent legal expert examine the formal responses of the health board to the concerns I submitted would be very simple and could be very illuminating and offer an opportunity to ‘learn lessons’. I have no doubt, despite the rhetoric, that the underlying intention will be to draw me in somehow, ‘seek my views’, and close down this saga without further potentially embarrassing investigation or action.
But I have discovered that my tale is absolutely typical of whistle-blowers (see safety expert Margaret Heffernan, or whistle-blowing experts such as Dina Medland or Kim Holt), both generally but especially within our current NHS.

What all front-line NHS staff, whether whistle blowers or not, have learned through bitter experience is that, despite government or Health Board rhetoric, it continues to be unsafe for staff to raise serious concerns about anything that might reflect badly on or cause ‘reputational’ damage to management or Health Boards or those responsible politically for them. Any such whistle blowing is certainly not going to be investigated seriously, and staff who attempt to whistle blow are almost certainly going to be victimised for their efforts. These pressures apply to management colleagues also who risk raising their voice or stepping ‘out of line’. Of course we have all seen inquiries (e.g. around grievances or administrative problems) done rigorously by health boards - but never when they threaten reputational damage. There is no genuinely-independent body with investigatory or disciplinary powers to address such concerns or to protect those who raise them.

Despite by now a vast literature world-wide on the importance of whistle blowing for safety and quality of services, and for their cost-effectiveness, whether NHS or in industry, there is clearly still a breath-taking lack of understanding or appreciation (‘wilful blindness’?) of the issues involved throughout the NHS and those responsible for it. These include especially its (often unconscious) systemic and group psychology e.g. denial, projection, scape-goating, cronyism, ‘in’ and ‘out’ groups, mobbing, smearing (whistle blowers are ‘difficult’, ‘disruptive’ or ‘vexatious’), vendettas, black-listing, or the psychologically traumatic effects on those involved. All of these issues were clearly described and summarised in the classic ‘Private Eye’ supplement (‘Shoot the Messenger’) published several years ago (still accessible on line), and, over the years, various aspects of them by writers such as Margaret Heffernan, Dina Medland, Kim Holt, Penelope Campling, Onora O’Neill or Robert Francis QC. The supplement included a list of well-recognised ‘dirty tricks’ for dealing with and silencing whistle blowers. These include trumped-up complaints about their competence, blaming them for the very problems they highlight, suspension due to their ‘difficulty’, referral to regulatory bodies (eg the GMC or NMC), commissioning and managing ‘reassuring’ limited ‘inquiries’ internally, endless administrative ‘delays’, gagging ‘agreements’, or effective black listing.

The idea, furthermore, that any institution can be trusted to manage any investigation into its own possible shortcomings is by now, in the 21st century, dead in the water - or should be - following decades of scandals and experience in the UK and world-wide.

But effective ‘whistle blowing’ is well recognised to be of massive importance for the delivery of safe, high quality, and cost-effective services, for the well-being of patients, for the well-being and morale of staff upon which good governance and care critically depends, and overall for proper accountability and transparency of a major public service. Front line staff are now additionally obliged by a ‘duty of candour’ to raise concerns where they become apparent, with legal consequences (such as being ‘struck off’ or prosecuted) if they do not. Curiously and discrepantly, no such legal ‘duty’ applies to senior management nor are they ever held legally accountable for wrong-doing or incompetence, as would occur in the private sector for example. (Airline managers not being held accountable for plane crashes due to management incompetence?). Senior Government advisers state this would be bad for their morale! But the same consideration does not seem to apply to front line staff.

As NHS staff surveys consistently show, the majority of front-line colleagues no longer trust management and would not whistle blow, would not recommend the NHS as a place of work, and something like an astonishing 15% (more in NHS Lothian recently) of the work force feel they are actively (as opposed to potentially) being bullied at work. The NHS also increasingly experiences major problems with recruitment, retention of staff and of chronically high stress and sickness rates. All of this would be regarded as catastrophic and a major cause for concern in any independent sector organisation.

On top of this, in almost Orwellian fashion, successive governments, for their own obvious reasons, continually insist that ‘less is more’ and we have a happy, harmonious, progressive
health service of world-class standard, that is safe, person-centred and staff-friendly. I do not know of a single front-line colleague who would subscribe to such a view. It is not the critical picture painted by reports from respected agencies such as the OECD, the Nuffield Trust, the Swedish 'Health Consumer Powerhouse' think-tank, or indeed in Scotland by e.g. Audit Scotland reports.

But I have also learned that whistle blowing cannot be considered apart from the broader managerial and also socio-political culture in which the NHS is embedded. The latter includes a culture that is apparently well-recognised historically to be highly authoritarian and whose public life is characterised, perhaps inevitably in a small country and not all for the worse, by an extensive 'interconnectedness' (or cronyism). This clearly extends through public services, civil service agencies, legal, political and even media circles. Frequently the same people rotate around important posts in these different spheres. I have learned also that the judicial system in Scotland appears notably reluctant to pursue any such concerns even when formally reported to them, and certainly not, it seems, if reassuring 'inquiries' have been undertaken by Health Boards. This is in marked contrast eg to the automatic inquiries held promptly by coroners' courts in England.

The overall management culture of NHS Lothian I encountered and described by David Bowles a few years ago (following the waiting-list manipulation scandal) as characterised by 'bullying harassment and covering up' has become, if anything, apparently more toxic, dysfunctional and unaccountable. Staff morale is appalling, despite (predictable but non evidence-based) claims of positive change by the health board. These claims are not supported by recent NHS staff surveys.

During this period I had also, in despair, and following due process, directly contacted successive Cabinet Secretaries for Health for help and to express my concern that these issues were not being properly investigated by NHS Lothian (on the contrary they were being covered over), and also that I was being victimised for whistle blowing. However despite reassuring rhetoric ("we take these matters very seriously indeed"!) the upshot was simply that yet again the whole saga was simply mandated back to the health board. They of course 'reassured' them that all was being properly investigated and handled. (A complaint against a local police force yet again being investigated by themselves). Even when following media publicity the matter was raised in Parliament the then First Minister (Alex Salmond) simply proffered in typical 'assertive' style the 'reassurances' he had received from the health board about reassuring 'independent' inquiries, but without addressing the substantive issue of my complaints. And yet the former FM is fond of saying that the "a lie can get half way round the world before the truth can get its boots on", or of demanding genuinely-independent, in-depth inquiries when it suits e.g. into whistle blowing by a Navy submariner, or about UK Treasury 'leaks' during a referendum! However it seems previous governments also (including the previous Lab-Lib coalition) have all adopted similar approaches, adopting a convenient 'wilful blindness', with regard to the importance of whistle-blowing in the governance of the NHS and public services.

I also contacted the whistle-blowing helpline (run by PCaW) – Public Concern at Work) which, as it routinely does, simply referred me back to the very Health Board I was trying to raise concerns about. They they have no investigatory powers themselves. This was a totally demoralising experience and in terms of its effectiveness was completely risible and a sham.

*It remains the case that my formal complaints have never been properly investigated or in several instances never investigated at all. Furthermore the only inquiries that have been conducted have all been commissioned and managed by NHS Lothian themselves and have been undertaken either internally, or by colleagues previously involved in reports on the service, and involved with its development.*

**Some final thoughts and conclusions**
In many ways I feel I was very lucky to ‘escape’ from this situation with an early, although greatly-reduced, pension due to my seniority, and despite the fact that I (and my family) have been profoundly shaken and traumatised. Others, who may also have been gagged (or ‘super-gagged’), have not been so lucky. But I do feel at least, despite the massive cost to my career, reputation, health, and to my family, that I did ‘the right thing’ and did act properly out of a ‘professional conscience’ and a ‘duty of candour’. (Amongst other things I suffered years of poor sleep with recurrent bad dreams, teeth grinding and broken teeth, and developed severe phobias about anything (e.g. mail) to do with NHS Lothian). However I had intended to work on much longer and now two consultants are having to cover the (part-time!) post I left. Given the worsening NHS recruitment crisis this is clearly both a serious waste of both manpower and money. I am also still recurrently very upset to think that had my concerns been taken seriously initially, as should have occurred, many patients would have received much better care and that, possibly, some might still be alive who are not.

With regard to broader questions for the future, I would simply repeat suggestions that I and other whistle blowers in Scotland have previously made. These include the urgent undertaking of an in-depth, genuinely-external, ‘root and branch’ review (conducted by an expert group with many members from outside Scotland, and also ‘experts by experience’) of the overall structure and managerial culture of the NHS extending all the way into government. Such a review should also include, as a matter of urgency, in-depth surveys and focus groups of the real-life experiences and views of all workers in the health service with regard to NHS managerial culture and governance. These should include especially those incomers or returnees who have worked in and have comparative experience of other countries and cultures. The various political parties in Scotland always seemed very ready to undertake surveys and focus groups when an election is looming.

These suggestions would also include the setting up of a genuinely-independent regulatory body with investigatory powers to whom whistle blowers and others (e.g. patients or families with complaints) may turn. And these would also include the urgent need to promote (easier said than done of course) a culture of a genuine transparency and accountability in the management of the NHS, extending right to the top and to its political stewards, and including a broader ‘establishment’ culture where there is a genuine, prompt, impartial application and ‘rule of law’. This would clearly also require the rolling out of awareness and training initiatives around the issues involved (especially systemic and psychological ones) in speaking out or ‘whistle blowing’ in a public services like the NHS, akin to those now routinely mandated for all staff in relation to ‘equality and diversity’. Present, essentially government-controlled ‘internal’ agencies such as Health Care Improvement Scotland (HIS) or the MWC simply do not meet these criteria. Whistle blowers cannot approach the public services ombudsman, and current judicial processes such as Fatal Accident Inquiries (FAIs) are simply not fit for purpose in this context, and certainly as compared e.g. to coroner’s court procedures in England.

To address the problems of the NHS will require civic pressure and cross-party political will, but there does exist it seems to me a massive opportunity. Health boards cannot be allowed to be judge, jury and jailer for any concern or complaint that is raised, nor should the shocking practice of protection and covering up for them in administrative or political power be accepted.

Despite the damage done to clinical effectiveness and staff morale in recent years by a culture of unaccountable ‘managerialism’, it is perhaps not too late to rescue and resuscitate some of the human commitment, care and compassion which motivated health care staff in the first place, but which has been increasingly squeezed out of them. This is the ethos that is critical to the delivery of high quality, person-centred, compassionate care. It is also recognised to be fundamental to and a sine qua non of safety. Arguably the operation and character of this major public service should be seen as a barometer and indicator of the health and well-being of civic society in general in Scotland. Based on my traumatising personal experiences and the apparent ‘direction of travel’ of NHS governance I am not very optimistic.
Dear Sir/Madam,

Paul Gray (“All NHS workers should have the right to speak up without fear”, Agenda, The Herald, 26 September) appears to be waking up to the problems facing staff in 'whistle blowing' in the NHS and their implications for its overall effectiveness, including the quality and safety of services, and the well-being of patients and of front-line staff. This despite his previous denials that any such problems existed. Any meaningful initiatives to address the scandal of what happens to whistle-blowers when they challenge management or the reputation of Health Boards are to be welcomed. But this will not be achieved by 'helplines', chat sites, or group huddles about practical problems. As Donnie Ross notes, a 'root and branch' review is required, including of the highly authoritarian, 'top-down', managerial culture now prevalent in the NHS. This is well documented by David Bowles (in NHS Lothian), the Paterson report, the recent BMA consultants' survey, by nursing and union spokespersons, and NHS staff surveys. Others, including myself, have advocated a genuinely-independent body with investigatory and disciplinary powers, not simply a National Whistle-Blowing Officer.

Paul Gray concludes by urging those whose concerns are not being listened to to come forward and 'tell him'. As one of the whistle-blowers mentioned in your coverage, I did just that and approached Mr Gray formally two years ago having fruitlessly exhausted internal procedures within NHS Lothian. His response was to refer the matter back to the very Health Board where I had raised serious concerns about the safety and quality of a new perinatal psychiatry service and its management. This is akin to asking a local police force to investigate a complaint against itself. NHS Lothian managed their own 'external' review of my saga and its outcomes. The concerns I raised were never properly investigated, I was forced out of my job and initially subject to a 'gagging clause' in a settlement agreement 'offered' to me. I was subject to a 'smear' campaign, had my specialist career destroyed, and have effectively been blacklisted in Scotland. The concerns I raised, (although this should not need to be the case), have been vindicated piece-meal by the findings of a few limited inquiries, by a series of critical incidents including maternal deaths, and, recently, by the damning verdict of the Mental Welfare Commission (Herald 8/9/16) on the treatment by NHS Lothian of a woman with a post-natal psychosis who killed her baby.

The 'external' review commissioned by Lothian, at Mr Gray's instigation, was in fact critical of the setting-up and management of the perinatal service and of my treatment, but NHS Lothian refuse to publish this citing 'confidentiality'. I would be astonished if NHS Lothian furnished the MWC with any of these documents. This is hardly the culture of transparency that Mr Gray advocates. I have discovered that my tale is absolutely typical of whistle-blowers (see safety expert Margaret Heffernan or whistle-blower Kim Holt), especially within our current NHS.

Given his invitation, I would welcome a meeting with Mr Gray to review outstanding issues around my saga and the responses of the Health Board involved.

Yours sincerely,

(Dr) Jane Hamilton (Consultant Psychiatrist).
Whistle Blowing and Governance in the NHS in Scotland: Personal Reflections.

Dr Jane Hamilton

Initiatives around whistle blowing and governance in the NHS in Scotland have been in the news again over the past few months. Whether this will lead to any significant change seems to me very unlikely for a variety of reasons. Amongst other things the Scottish government has recently concluded another public ‘consultation’ exercise, the public petitions committee at Holyrood has been taking contributions on the subject, and the Health and Sport Committee (chaired by Neil Findlay MSP) has announced an inquiry into governance and whistle blowing in the NHS. A recent issue of BBC radio ‘File on Four’ revisited the same issues across the UK featuring various whistle blowers, including myself. The outcomes of these sagas, several years on from the scandal at Mid-Staffs and the Francis report, personally and for the NHS, was uniformly depressing.

The government has also mandated Health Boards to appoint whistle-blowing 'champions' although it turns out the Health Boards have, for the most part, appointed existing executive members - some of whom have been involved in alleged instances of victimisation of whistle-blowers or of covering up of wrong-doing and of incompetence. The identity of some of these 'champions' has apparently not even been revealed to employees! Curiously, they have nowhere appointed 'experts by experience' – although this this strategy has been adopted in many parts of the world. It is also proposed to appoint a (single) independent national (whistle blowing) officer (INO).

Paul Gray (CEO of NHS Scotland) has recently published a welcome acknowledgement - long overdue - that whistle blowing may be a problem for staff in the NHS. He concluded his piece by urging those whose concerns are not being listened to to come forward and 'tell him'. As one of the whistle-blowers mentioned, I had in fact done just that and approached Mr Gray formally two years before having fruitlessly exhausted internal procedures, and been victimised for doing so, within NHS Lothian. At that time the baby (Zoe Sutherland), about whose death he commiserated on Radio 4, was still alive. His response was to refer my concerns back to the very Health Board where I had raised serious concerns about the safety and quality of the new perinatal psychiatry service and its management. This is akin to asking a local police force to investigate a complaint against itself. NHS Lothian then managed their own 'external' review of my saga and its outcomes.

The various concerns I raised formally were never properly investigated, and were deferred and then buried until I was was forced out of my job. I was initially subject to a widely-publicised 'gagging clause' in a settlement agreement 'offered' to me. I was subject to a demonstrably false 'smear' campaign, had my specialist career (and a large treatment trial for stressed and depressed pregnant women) destroyed, and have effectively been blacklisted in Scotland. The concerns I raised, (although this should not need to be the case), have been vindicated piece-meal by the findings of a few limited inquiries, by a series of critical incidents including maternal deaths, and, recently, by the damning verdict of the Mental Welfare Commission (MWC) on the treatment by NHS Lothian of the woman (Ms OP) with a post-natal psychosis who killed her baby. For the most part the recommendations of such inquiries as did occur have not been implemented.

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I met recently with Paul Gray following his public statement, although only at my insistence and following further media exposure, to present my ongoing concerns. He has since stated publicly on Radio 4 that he takes my concerns 'seriously' and wishes to obtain my 'assistance' in moving forward - although not I suspect in properly investigating my saga, nor wrong-doing and incompetence in NHS Lothian - with its serious implications for safety and quality of services and for managerial culture in the NHS more generally as well as locally. To have an independent legal expert examine the formal responses of the health board to the concerns I submitted would be very simple and could be very illuminating and offer an opportunity to 'learn lessons'. I have no doubt, despite the rhetoric, that the underlying intention will be to draw me in somehow, 'seek my views', and close down this saga without further potentially embarrassing investigation or action.

But I have discovered that my tale is absolutely typical of whistle-blowers (see safety expert Margaret Heffernan, or whistle-blowing experts such as Dina Medland or Kim Holt), both generally but especially within our current NHS.

What all front-line NHS staff, whether whistle blowers or not, have learned through bitter experience is that, despite government or Health Board rhetoric, it continues to be unsafe for staff to raise serious concerns about anything that might reflect badly on or cause 'reputational' damage to management or Health Boards or those responsible politically for them. Any such whistle blowing is certainly not going to be investigated seriously, and staff who attempt to whistle blow are almost certainly going to be be victimised for their efforts. Incidentally, these pressures apply also to management colleagues who risk raising their voice or stepping 'out of line'. Of course we have all seen inquiries (e.g. around grievances or administrative problems) done rigorously by health boards - but never when they threaten reputational damage. There is no genuinely-independent body with investigatory or disciplinary powers to address such concerns or to protect those who raise them. The so-called 'help line' is a joke (callers are simply referred back the to the very Health Boards they are concerned about), as are recently promoted, anonymous 'chat sites'.

Despite by now a vast literature world-wide on the importance of whistle blowing for safety and quality of services, and for their cost-effectiveness, whether NHS or in industry, there is clearly still a breath-taking lack of understanding or appreciation ('wilful blindness'?!) of the issues involved throughout the NHS and those responsible for it. These include especially its (often unconscious) systemic and group psychology e.g. denial, projection, scape-goating, cronyism, 'in' and 'out' groups, mobbing, smearng (whistle blowers are 'difficult', 'disruptive' or 'vexatious'), vendettas, black-listing, or the psychologically traumatic effects on those involved.

All of these issues were clearly described and summarised in the classic 'Private Eye' supplement ('Shoot the Messenger') published several years ago (still accessible on line), and, over the years, various aspects of them by writers such as Margaret Heffernan, Kim Holt, Penelope Campling, Onora O'Neill or Robert Francis QC. The supplement included also a list of well-recognised 'dirty tricks' for dealing with and silencing whistle blowers. These include trumped-up complaints about their competence, blaming them for the very problems they highlight, suspension due to their 'difficulty', referral to regulatory bodies such as the GMC or NMC, commissioning and managing 'reassuring' limited 'inquiries' internally, endless administrative 'delays', gagging 'agreements', or effective black listing.

The idea, furthermore, that any institution can be trusted to manage any investigation into its own possible shortcomings is by now, in the 21st century, dead in the water - or should be - following decades of scandals and experience in the UK and world-wide.

But effective 'whistle blowing' is well recognised to be of massive importance for the delivery of safe, high quality, and cost-effective services, for the well-being of patients, for the well-being and morale of staff upon which good governance and care critically depends, and overall for proper accountability and transparency of a major public service. Front line staff are now additionally obliged by a 'duty of candour' to raise concerns where they become apparent, with legal consequences (such as being 'struck off' or prosecuted) if they do not. Curiously and discrepantly, no such legal 'duty' applies to senior management nor are they ever held legally accountable for
wrong-doing or incompetence, as would occur in the private sector for example. (Airline managers
not being held accountable for plane crashes due to management incompetence?). Senior
Government advisers state this would be bad for their morale! But the same consideration does not
seem to apply to front line staff.

As NHS staff surveys consistently show, the majority of front-line colleagues no longer trust
management and would not whistle blow, would not recommend the NHS as a place of work, and
something like an astonishing 15% (more in NHS Lothian recently) of the work force feel they are
actively (as opposed to potentially) being bullied at work. The NHS also increasingly experiences
major problems with recruitment, retention of staff and of chronically high stress and sickness
rates. All of this would be regarded as catastrophic and a major cause for concern in any
independent sector organisation.

On top of this, in almost Orwellian fashion, successive governments, for their own obvious
reasons, continually insist that 'less is more' and we have overall a happy, harmonious, progressive
health service of world-class standard, that is safe, person-centred and staff-friendly. I do not know
of a single front-line colleague who would subscribe to such a view. It is also not the highly critical
picture painted by reports from respected outside agencies such as the OECD, the Nuffield Trust,
the Swedish 'Health Consumer Powerhouse' think-tank, or indeed in Scotland by e.g. Audit
Scotland reports.

Meantime NHS Lothian continue, to my ongoing amazement, to repeat their mission statement at
the foot of all communications: “Our Values Into Action - Quality | Dignity and Respect | Care and
Compassion | Openness, Honesty and Responsibility | Teamwork”. As one colleague quipped -
“They're only kidding!”. Or as another colleague put it in a more sinister tone 'forget it Jane – its
Chinatown...’

Some background considerations

But I have also learned that whistle blowing cannot be considered apart form the broader
managerial and also socio-political culture in which the NHS is embedded. The latter includes a
culture that is apparently well-recognised historically to be highly authoritarian and whose public
life is characterised, perhaps inevitably in a small country and not all for the worse, by an
extensive 'interconnectedness' (or cronism). This clearly extends through public services, civil
service agencies, legal, political and even media circles. Frequently the same people rotate around
important posts in these different spheres. Partly for these reasons I remain pessimistic about any
imminent serious change apart from more cosmetic, 'sound-bite', type initiatives especially given
again currently a political preoccupation with constitutional questions.

In England an increasing commercialisation of the NHS has generated its own particular problems.
But a 'Beveridge' style, publicly-funded and run NHS (i.e. a virtual state monopoly) is no guarantee
against the Soviet-style authoritarian managerialism and cronism noted by authorities such as
Brian Jarman, or John Lees in mental health. Both systems are characterised and seriously
undermined by the so-called 'New Public Management' style of managerialism. As has been noted
in an extensive critical literature, this can lead to a damaging 'commodification' of health care and
privileging of supposed 'cost effectiveness' (usually it is not) and meeting 'targets' above quality
and safety of care. Treating staff also as functional commodities to be treated with suspicion and
'big sticks' also fatally undermines any 'public service ethos' – i.e. a culture of compassion and care
and of staff willing to work over and above the call of duty or 'go the extra mile'. All of these are
recognised to lie at the core of safe and effective health care. Rather, as staff surveys and e.g.
college and union reports show, colleagues are defensive, feel frequently bullied, become cynical,
stressed out, and get out if they can.

Overall there has been a massive swing of the pendulum from largely clinical leadership and
management (which had its own historic problems) - to one run by managers. These are often non-
clinicians with little or no experience or expertise in the areas they are responsible for, nor,
importantly, do many have any apparent interest in or respect for those who do. Indeed, some
gmanagerial staff appear to have adopted an almost vindictive, persecutory, vendetta (‘our turn
now’) like approach to managing front-line and especially clinical colleagues.

I have learned also that the judicial system in Scotland appears notably reluctant to pursue any
such concerns even when formally reported to them, and certainly not, it seems, if reassuring
‘inquiries’ have been undertaken by Health Boards. This is in marked contrast eg to the automatic
inquiries held promptly by coroners’ courts in England.

My initial experience of moving to lead a specialist perinatal psychiatry service in NHS
Lothian

My own personal saga in NHS Scotland began almost a decade ago when I was recruited from a
major centre in England as an established specialist in my field of perinatal (mother and baby)
psychiatry to lead the newly-established NHS Lothian and East of Scotland regional perinatal
service. This was located at St John's Hospital in Livingston although no specialist mental health
services had ever been delivered there before. I was a long established consultant (in London and
Sheffield) with 25 years clinical experience and an impeccable record. I had been awarded
numerous clinical excellence points, had a PhD and various papers in clinical research, and had
been co-author of internationally-recognised 'NICE' guidelines in perinatal psychiatry. I had also
brought an ongoing major clinical trial I had previously set up of psychological treatment for
pregnant women with mental health problems which I was encouraged to do. This is currently and
belatedly being recognised as an area of major need and concern by the Scottish government. But
this trial, along with my specialist career, was destroyed by subsequent events.

Prior to coming I had in fact been warned about cronyism, authoritarianism and resistance to
incomers by various colleagues back in England. However I rather naïvely assumed that as I was
moving as an established specialist consultant to a new service, this move would surely be
supported managerially and I would be welcomed given my expertise and experience in the field.
Nothing could be further from the truth, and nothing prepared me for what I encountered.

Virtually from the beginning I was extremely concerned at the lack of specialist training and
supervision for staff and of resistance to them. I was told for example 'We will do things our own
way and learn from our own mistakes'. There was a lack of appreciation of the needs of a regional
service in a high-risk specialty for safe and prompt communications, for clear referral criteria, and
the need for in-depth and accurate assessment procedures and triaging, given that obviously not
all women with less serious perinatal illness could be admitted (with babies) to a very small
specialist regional service.

Importantly, I also discovered that managerial and clinical decisions were much more liable to be
influenced by who knew whom locally, and how long people had been around, rather than on the
basis of expertise or appropriate clinical need. I discovered clinical decisions I attempted to make
were being routinely undermined or countermanded by other colleagues or managers who knew
the local (in fact only 'acting') clinical director from many years before. Furthermore, plans and
decisions about the nature of services and how clinicians should operate were apparently also
being mandated and dictated to by local management, some of whom had no clinical background
whatesoever, and certainly none in such a demanding specialty - but who, as I discovered, one
crossed at one's peril.

In short, I had never, over a period of some 25 years in clinical practice in many settings, urban
and rural, academic and community, in the UK, and through acquaintanceship with various
services overseas, come across what I considered such poor and unsafe practice, and had never
come across such obstructiveness to reform or improvement from local managerial and clinical
colleagues. This appeared to me without doubt compounded by the fact that I was had come in as
an outsider, and as a woman, from England, and been appointed over the head of a local, but non-
specialist, candidate.
Having said all this I also came across a number of very committed, caring and morally decent colleagues, both front-line clinical and non-clinical staff, as well as managerial, who were also frustrated in their attempts to improve things in the face of such a managerial culture and who suffered personally and professionally because of it.

Given this situation I was faced early on with trying to improve the situation or get out. I naively took the first course, in part perforce due to having just uprooted and moved my family and my spouse (from a top NHS post) from central England.

Attempts to enlist help and raise concerns (whistle blow) and subsequent experience of senior management in NHS Lothian (victimisation).

But when I attempted to address these issues and get help from local management I was either ignored or undermined, and very firmly told, despite my expertise and specialist experience, I should conform to what local and other colleagues ('old pals' of management) wanted. I was told by local management, with no negotiation and in no uncertain terms, to do what I was told - or 'there would be consequences'. Despite being appointed on only a part-time contract ('cost effectiveness!') with no proper job plan, I was mandated to cover various clinics locally and in Edinburgh, to provide input to obstetric liaison services, to a community team and to an in-patient unit! (My 'job plan' was wholly inadequate and was never clarified or ratified in clear breach of statutory requirements to do so and despite my efforts to negotiate one). Unsurprisingly, many colleagues became frustrated at the lack of input available after early management promises of a new, comprehensive service.

I quickly discovered that management in NHS Lothian would repeatedly and without any concern for accountability or transparency, break statutory and government (e.g. PIN) guidelines with regard to contracts, job plans, clinical inquiries, disciplinary procedures, terms and conditions of settlement 'agreements', return to work procedures, or salary scale placement.

Within a year of being appointed, a number of untoward and critical incidents had begun to occur as I feared (one involving the poor care and follow-up of a mother and baby that almost led to the death of a baby that has to this day had no formal outcome or response within NHS Lothian). These incidents presaged several fatalities that subsequently occurred (including the one criticised by the MWC recently). I then felt obliged to approach senior management (in writing), in despair and frustration, and in retrospect rather naively. But I considered this was my professional and moral 'duty of candour', and had consulted the BMA, my defence union, and GMC formally about the situation and its potential consequences for patient care.

I formally approached both the then medical director and CEO of NHS Lothian. To my astonishment, they simply referred matters back to local management, who obviously reassured them that things were fine, and that this was essentially an employment issue relating to my job plan, and that I was being 'difficult'.

Then began a nightmare Kafka-esque period extending over half a dozen years, during which I was subject to inquiries in relation to a series of false allegations about me, which were unsubstantiated and ultimately unproven. During the course of these I was subjected to a nightmare process, including being blocked from my post and forced to go through a humiliating assessed period of 'return to work' under inappropriate procedures for failing doctors (and using headings from the initial complaint despite this not having been upheld), and with threats of referral to the GMC if I did not comply!

These various false allegations (mostly by management colleagues well-known to the (internal) investigator) were initially simply taken as read, despite lack of evidence, and despite documentary counter evidence supplied by me (including many testimonials from previous colleagues). This was simply ignored. Neither I nor my defence representatives (typical for these Health Board inquiries I
have learned) were permitted to challenge or cross examine ‘evidence’ against me.

Furthermore, government ‘PIN’ (Partnership Information Network) guidelines regarding the conduct of such inquiries (such as the mandatory requirement for prompt, formal written feedback, or the right of appeal) were repeatedly simply ignored and breached. Later, the completely inappropriate ‘return to work’ framework for dealing with failing doctors was imposed on me implying inaccurately, but conveniently of course, that I, rather than management, had had problems.

I was also subject to a doomed so-called ‘mediation’ process with local colleagues about many of whom I had implicitly raised concerns and some of whom had perpetrated false allegations and smears about me. Some staff involved with this I had never actually met before!

All of this inappropriately and incompetently drawn-out process occurred of course at very considerable tax payers’ expense (more than a million pounds as was ascertained from a FOI request by the press, see Sunday Times 24/10/14) whilst services were covered by a series of locums, and whilst also paying for various inquiries ultimately conducted by NHS Lothian - although only at my insistence. Money was then squandered on costly legal fees and ultimately a settlement ‘agreement’ pay off for myself. The details of this I have been happy to place in the public domain, although most went in my own legal fees and tax.

I had in the meantime also submitted to NHS Lothian, in despair and frustration, detailed and lengthy complaints (with supporting evidence) about wrong-doing and incompetence around the service and its management as well as about false allegations that had been made about myself. Although an initial meeting was held with a senior manager mandated to investigate these, I was astonished to find that they were subsequently simply placed ‘on hold’ for a year and half whilst, as it turned out, and as I know from inside sources, the Health Board frantically worked on some way of ‘dealing with me’, and getting rid of me.

Ultimately, I was summoned to a meeting with board level senior management and told that I could not return to my post - despite my having acted properly and professionally at all times - and despite their lack of investigation (‘wilful blindness’) into the very serious concerns I had raised, and which still prevailed, about safety and quality of services.

In the meantime, as I had predicted, a series of further critical incidents occurred, many of them not investigated properly or other than by the people involved locally or by colleagues previously known to NHS Lothian. These ultimately included maternal deaths and more recently the death of a baby killed by her psychotic mother.

But the official ‘public’ position that the health board has, for obvious reasons, attempted to maintain (they would!), and despite considerable evidence to the contrary, most recently the MWC report, was that all of my concerns were addressed and investigated and that various inquiries have found that the service and its management were of good quality. They have repeated this ‘boiler plate’ so often that it frequently actually seems that senior management collectively believe this. However I know from internal sources and leaks that the handling of my case provoked much discomfort and disagreement within the Health Board throughout, although ultimately a ‘party whip’ was obviously imposed and a predictable, defensive standard script issued.

The overall management culture of NHS Lothian I encountered and documented by David Bowles a few years ago (following the waiting-list manipulation scandal) as characterised by ‘bullying harassment and covering up’ has by all accounts, become, if anything, apparently more toxic, dysfunctional and unaccountable. Staff morale is appalling, despite (predictable but non evidence-based) claims of positive change by the health board. These claims are certainly not supported by recent NHS staff surveys.
Experiences of trying to raise concerns beyond the Health Board

During this period I had also, in despair, and following due process, directly contacted successive Cabinet Secretaries for Health for help and to express my concern that these issues were not being properly investigated by NHS Lothian (on the contrary they were being covered over), and also that I was being victimised for whistle blowing. However despite reassuring rhetoric ("we take these matters very seriously indeed!") the upshot was simply that yet again the whole saga was simply mandated back to the health board. They of course 'reassured' them that all was being properly investigated and handled. (A complaint against a local police force yet again being investigated by themselves). Even when following media publicity the matter was raised in Parliament the then First Minister (Alex Salmond) simply proffered in typical 'assertive' style the 'reassurances' he had received from the health board about reassuring 'independent' inquiries, but without addressing the substantive issue of my complaints. As if no major institutional scandal or victimisation of whistle blowers had occurred anywhere in the world over the past generation. And yet the former FM is fond of saying that the "a lie can get half way round the world before the truth can get its boots on", or of demanding genuinely-independent, in-depth inquiries when it suits e.g. into whistle blowing by a Navy submariner, or about UK Treasury 'leaks' during a referendum! However it seems previous governments also (including the previous Lab-Lib coalition) have all adopted similar approaches, adopting a convenient 'wilful blindness', with regard to the importance of whistle-blowing in the governance of the NHS and public services in Scotland.

I also contacted the so-called whistle-blowing helpline (run by PCaW) – Public Concern at Work) which, as it routinely does, simply referred me back to undergo due process through the very Health Board I was trying to raise concerns about. They they have no investigatory powers themselves. This was a totally demoralising experience and in terms of its effectiveness was completely risible and a sham. As much use as the proverbial chocolate tea pot.

It remains the case that my formal complaints have never been properly investigated or in several instances never investigated at all. Furthermore the only inquiries that have been conducted have all been commissioned and managed by NHS Lothian themselves and have been undertaken either internally, or by colleagues previously involved in reports on the service, and involved with its development.

Some final thoughts and conclusions

In many ways I feel I was very lucky to 'escape' from this situation with an early, although greatly-reduced, pension due to my seniority, and despite the fact that I (and my family) have been profoundly shaken and traumatised. Others, who may also have been gagged (or 'super-gagged'), have not been so lucky. But I do feel at least, despite the massive cost to my career, reputation, health, and to my family, that I did 'the right thing' and did act properly out of a 'professional conscience' and a 'duty of candour'. (Amongst other things I suffered years of poor sleep with recurrent bad dreams, teeth grinding and broken teeth, and developed severe phobias about anything (e.g. mail) to do with NHS Lothian). However I had intended to work on much longer and now two consultants are having to cover the (part-time!) post I left. Given the worsening NHS recruitment crisis this is clearly both a serious waste of both manpower and money.

However I am also still recurrently very upset to think that had my concerns been taken seriously initially, as should have occurred, many patients would have received much better care and that, possibly, some might still be alive who are not.

In the wake of my own experiences sadly however, my advice at present to others thinking of whistle blowing (whatever current government rhetoric) would be to keep your head down, and don't even think about it. Get out if you can. Or if you do, be prepared for savage and damaging consequences for yourself and possibly others. As one colleague of mine put it at the time "who would dream of raising concerns when you see what happened to Dr Hamilton when she did..."
With regard to broader questions for the future, I would simply repeat suggestions that I and other whistle blowers in Scotland have previously made. These include the urgent undertaking of an in-depth, genuinely-external, 'root and branch' review (conducted by an expert group with at least many members from outside Scotland, and also 'experts by experience') of the overall structure and managerial culture of the NHS extending all the way into government. Such a review should also include, as a matter of urgency, in-depth surveys and focus groups of the real-life experiences and views of all workers in the health service with regard to NHS managerial culture and governance. These should include especially those incomers or returnees who have worked in and have comparative experience of other countries and cultures. The various political parties in Scotland always seemed very ready to undertake surveys and focus groups when an election is looming.

These suggestions would also include the setting up of a genuinely-independent regulatory body with investigatory powers to whom whistle blowers and others (e.g. patients or families with complaints) may turn. And these would also include the urgent need to promote (easier said than done of course) a culture of a genuine transparency and accountability in the management of the NHS, extending right to the top and to its political stewards, and including a broader 'establishment' culture where there is a genuine, prompt, impartial application and 'rule of law'. This would clearly also require the rolling out of awareness and training initiatives around the issues involved (especially systemic and psychological ones) in speaking out or 'whistle blowing' in a public services like the NHS, akin to those now routinely mandated for all staff in relation to 'equality and diversity'.

Present, essentially government-controlled 'internal' agencies such as Health Care Improvement Scotland (HIS) or the MWC simply do not meet these criteria. Whistle blowers cannot approach the public services ombudsman, and current judicial processes such as Fatal Accident Inquiries (FAIs) are simply not fit for purpose in this context, and certainly as compared e.g. to coroner's court procedures in England.

It remains to be seen whether there really is any remotely serious senior managerial or ultimately political will to undertake any of this - so-called consultation exercises apart. But without doubt change will also need to come through public pressure and demand, and a refusal to put up with such a managerial and political culture for public service(s) in Scotland (health and social care are now merging), in an allegedly democratic, civilised country in the 21st century. To address the problems of the NHS will require civic pressure and political will, but there does exist it seems to me a massive opportunity in doing so. The new NHS merging with social care urgently needs to develop a culture of genuine transparency and accountability. Health boards can no longer be allowed to be judge, jury and jailer for any concern or complaint that is raised, nor should the shocking practice of protection and covering up for them by these in administrative or political power be accepted.

Despite the damage done to clinical effectiveness and staff morale in recent years by a culture of unaccountable 'managerialism', it is perhaps not too late to rescue and resuscitate some of the human commitment, care and compassion which motivated health care staff in the first place, but which has been increasingly squeezed out of them. This is the ethos that is critical to the delivery of high quality, person-centred, compassionate care. It is also recognised to be fundamental to and a *sine qua non* of safety. Arguably the operation and character of this major public service should be seen as a barometer and indicator of the health and well-being of civic society in general in Scotland. Based on my traumatising personal experiences and the apparent 'direction of travel' of NHS governance I am not holding my breath.

(5376 words)