STATEMENT OF SIR ROBERT FRANCIS QC FOR THE HEALTH AND SPORT COMMITTEE OF THE SCOTTISH PARLIAMENT AT THEIR HEARING ON 13 JUNE 2017

I, SIR ROBERT ANTHONY FRANCIS, say as follows:

Personal
1. I am grateful for the invitation by the Committee to attend their hearing and offer this statement as an introduction to my perspective on whistleblowing, or as I prefer to call it, freedom to speak up, in the National Health Service. I make this statement in a personal capacity and nothing in it should be understood to be endorsed by or made on behalf of any organisation with which I am involved, including those to which I expressly refer below.

2. By way of background, I am a barrister in self-employed practice at the Bar of England and Wales. I was called to the Bar in 1973, and took silk in 1992. I have been a Recorder since 2000, and am authorised to sit as a Deputy High Court Judge. I am a governing Bencher of the Honourable Society of the Inner Temple. Between 2003 and 2005 I was chairman of the Professional Negligence Bar Association. For many years I have specialised in medical law, in particular clinical negligence, in which I regularly act for claimants and defendants, professional regulation, in which I have generally assisted registered practitioners, medical ethical decision-making on behalf of those lacking capacity to make their own decisions. I am not a specialist in employment law in general or public interest disclosure in particular, but have a general knowledge of the area developed through the work I will describe below.

3. I have appeared professionally for core participants at a number of important public inquiries in England, including the Bristol Royal Infirmary Inquiry [report 2001], the Royal Liverpool Children’s Inquiry [report 2001], and the Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [report 2004]. I have chaired three independent inquiries into the care and treatment of persons who have been convicted of homicide while under the care and treatment of mental health services.

4. Of more central relevance to the Committee’s considerations I was appointed by the Rt Hon Andy Burnham, then Secretary of State for Health to chair the Independent Inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust [report February 2010], and the Rt Hon Andrew Lansley, his successor, to chair the subsequent Mid-Staffordshire NHS Foundation Trust Public Inquiry [report February 2013] and lastly by the Rt Hon Jeremy hunt, the current Secretary of State to lead the Freedom to Speak Up Review [report March 2015].

References:
5. Following on from this work I am now a non-executive director of the Care Quality Commission. I also have the honour of being the President of the Patients Association, Patron of the Florence Nightingale Foundation, and a trustee of the Point of Care Foundation, a charity dedicated to enhancing the capability of healthcare staff to provide high quality care to patients through support such as Schwartz Rounds, a Heads Of Patient Experience [HOPE] network and support for experienced based co-design. I am an honorary Fellow of the Royal College of Surgeons (England), the Royal College of Anaesthetists and the Royal College of Pathologists.

Perspective derived from the Mid Staffordshire inquiries

6. The story of the appalling experiences suffered by too many patients at Stafford Hospital shocked all who read about it, and the experience of meeting patients and their families as they shared their stories with me has motivated my continued involvement in the healthcare sector ever since. I have often been asked how such a departure from acceptable standards had gone undetected for so long. The answer is that in fact many people were aware of parts of the picture, but in adequate action was taken to address the concerns that many of them raised. There was evidence that over a number of years staff had repeatedly reported incidents which they attributed to inadequacies in staffing. Not only was there the feedback – and therefore encouragement to raise concerns – was rare, there was also highly worrying evidence of a culture of fear promoted by some staff resulting in some of those who raised concerns being victimised. The most striking example came from the evidence of Helene Donnelly who reported being pressurised by senior colleagues to falsify discharge times in A&E records in order to give an appearance of compliance with target waiting times. Her evidence of the impact of this on her is worth recalling. She told me the following:

The culture in the department gradually declined to the point where all of the staff were scared of the Sisters and afraid to speak out against the poor standard of care the patients were receiving in case they incurred the wrath of the Sisters. Nurses were expected to break the rules as a matter of course in order to meet target, a prime example of this being the maximum four-hour wait time target for patients in A&E. Rather than “breach” the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going along with this if the wait time was only being breached by 5 ... or 10 minutes and the patient had been treated ... [but] when wait times were being breached by 20–30 minutes or more and

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4 Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. They are increasingly used by NHS providers to assist in the support of the well-being of their staff.

5 Experience-based co-design (EBCD) is an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership. The approach is different to other service improvement techniques

6 For a full chronological account of the warning signs I found, please see chapter 1 of the Public Inquiry report [vol1 pp47 et seq]

7 See Chapter 2 paras 2.324-332 of the Public Inquiry report [Vol 1 pp222-225]
the patient had still not been seen, I was not prepared to go along with what was expected. I was concerned about the terrible effect that our actions were having on patient care. I did raise this with Sisters [X] and [Y], however their response was extremely aggressive basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players.8

The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged. I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.9

When she did report her concerns she was abused and threatened:

... [T]he first sister ... made it very clear that she was very displeased with me and the fact that I’d spoken out ... [T]hreats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me in – trying I think in a helpful way to tell me to, I quote “watch my back”, ... and people were saying, “Oh, you shouldn’t have done this, you shouldn’t have spoken out.” And then physical threats were made in terms of people saying that I needed to – again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.10

7. I made recommendations all of which were intended to assist in changing the negative culture which persisted in too many places in the NHS through a combination of emphasis on putting the patient at the centre of healthcare, regulation, leadership development, support for staff and, above all, increased openness, transparency and candour about matters of concern. Among the recommendations I made were those designed to bring about:

- An obligation on staff to report safety concerns and to give including action taken or reasons for not acting [R12][
- A legal duty of candour to patients [organisations and professionals] [R173-183][
- Banning of “gagging clauses” in “compromise” agreements [R175][
- Assessment of nursing applicants for compatible values and compassion [R188, 191][
- Enhancement of nurse leadership capability at all levels[R195-197][
- Strengthening of nursing professional voice [R201-206].

8. The great majority of my recommendations were accepted and steps taken to implement them. I draw particular attention to the following developments:

8 Chapter 1 para 1.197 of the Public Inquiry report [Vol 1 p 108]
9 Chapter 2 para 2.374 of the Public Inquiry report [Vol 1 p 235]
10 Chapter 22 para 22.18 of the Public Inquiry report [Vol 3 p 1504]
a. The creation of a legal duty of candour, aligned with obligations under commissioning arrangements. Compliance is overseen by the CQC.
b. An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office.
c. An improved system of inspection and rating of all NHS providers by CQC. A significant amount of information on which assessments are made derives from staff.

The Freedom to Speak Up Review

9. In 2014 Jeremy Hunt asked me to undertake a review of whistleblowing in the NHS, principally as a result of a number of reported experiences of staff who had suffered serious adverse consequences as a result of raising concerns. Although I received some helpful contributions from sources in Scotland, my remit was limited to considering the situation in England. On considering the evidence submitted to me I found that:
   • raising concerns could be a “harrowing and isolating process with reprisals”;
   • bullying and oppressive behaviour were common;
   • there was a lack of support for staff and confidence that there would be any effective action when concerns were raised;
   • concerns were often handled poorly;
   • people who spoke up too often suffered a devastating impact as a result of doing so;
   • employers often felt challenged in how to separate safety concerns from disciplinary issues, culpability and responsibility;
   • the area was not helped by an adversarial legalistic culture

The accounts offered by staff and former staff were often of considerable concern. A small selection of quotes form the evidence included in the report make the point”

   • I have often been so depressed by this experience that I have often considered suicide. I live in fear that the hospital will carry out its threat to sue me and take my home from me if I don’t pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers).
   • ...false allegations made under the cover of whistleblowing have left myself and a number of my colleagues deeply traumatised.
   • Colleagues often quietly agreed with my concerns but refused to speak out in fear of reprisals
   • (There is) a culture of delay, defend and deny.

10. I set out 20 Principles which I considered should inform and support a change of culture to make speaking part of the normal business of healthcare rather than a dangerous activity resulting in little action other than detrimental treatment for the member of staff brave enough to raise a concern. In summary they were:
1. Every organisation involved in providing NHS healthcare should actively foster a culture safety and learning in which all staff feel safe to raise concerns.

2. Raising concerns should be part of the normal routine business of any well-led NHS organisation.

3. Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

4. All employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.

5. Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from improvements made in response to the issues identified.

6. There should be opportunities for all staff to engage in regular reflection of concerns in their work.

7. All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

8. When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigation to establish the facts.

9. Consideration should be given at an early stage to the use of expert interventions to resolve conflicts rebuild trust or support staff who have raised concerns.

10. Every member of staff should receive training in their organisation’s approach to raising concerns and in receiving and acting on them.

11. All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.

12. Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

13. All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.

14. Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for
   a. Poor practice in relation to encouraging the raising of concerns and responding to them
   b. The victimisation of workers for making public interest disclosures
   c. Raising false concerns in bad faith or for personal benefit
   d. Acting with disrespect or other unreasonable behaviour when raising or responding to concerns.
   e. Inappropriate use of confidentiality clauses.
15. There should be an independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:
   a. Review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice.
   b. Advise NHS organisations where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect.
   c. Act as a support for local Freedom to Speak Up Guardians
   d. Provide national leadership on issues relating to raising concerns by NHS workers
   e. Offer guidance on good practice about handling concerns
   f. Publish reports on the activities of this office.

16. There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.

17. CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.

18. All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

19. All principles in this report should apply with necessary adaptation in primary care.

20. Legal protection for those who make public interest disclosures should be enhanced by extension of the prescribed bodies for this purpose and the extension of protection to student in nursing and medicine.

11. Implementing the recommendations associated with these principles not been as expeditious as some expected, but in my view there has been significant progress:
   a. I believe that every NHS Trust has now appointed a Freedom to Speak Up Guardian. A variety of approaches has been taken to the functions of the post, the experience and background of the persons appointed and the support offered. Time will help in the assessment of which approaches work better than others.
   b. The post of National Freedom to Speak Up Guardian has been set up and funded and appointed jointly by CQC, NHS Improvement and NHS England. While the post is hosted by CQC the Guardian works independently. An appointment has been made: Dr Henrietta Hughes. I respectfully suggest that she is asked to offer the Committee a summary of the work she has been undertaking, but it includes a number of events bringing together the local Guardians enabling them to share good practice, challenges, and to set up self-support networks.
   c. NHS England is working on a support scheme for staff who have lost their jobs as a result of speaking up.
d. Many trusts have reviewed their whistleblowing policies to ensure consistency with the Principles.

e. The case review function of the National Guardian’s Office is being developed and may be expected to commence operation in the near future.

**Conclusion**

12. I hope this short statement indicates the areas in which I may be of assistance to the Committee and I am naturally content to be asked to expand on any particular point.

6 June 2017

SIR ROBERT FRANCIS QC