CREATING A HEALTHIER NHS FOR WALES

Openness, transparency and raising concerns

A prescription from Welsh Council
The British Medical Association

An Association ‘both friendly and scientific to promote the medical and allied sciences and to maintain the honour and interests of the medical profession’.

The BMA is...
- A voluntary professional organisation
- A voice for doctors at home and abroad
- An independent trade union
- A scientific and educational body
- A publisher

BMA Cymru Wales represents over 7000 members in Wales from every branch of the medical profession, including medical students.
This booklet is the product of BMA Welsh Council’s Policy Day on raising concerns in the workplace.
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‘Whistleblowing’, ‘Protected Disclosure’ and ‘Raising Concerns’

‘Whistleblowing’ is a popular term applied to a situation where an employee raises concerns to people who have the power and willingness to take corrective action.

However, the term does carry with it some negative connotations.

For instance, the report from the office of the Older People’s Commissioner for Wales: ‘Protection of older people in Wales: Raising Concerns in the Workplace’ stated that:

“the word ‘whistle-blowing’ has become seriously tainted and induces feelings and uncertainties that cause worry and may seriously inhibit a person’s freedom to raise concerns... a move to the use of a different term may well give scope for fresh thinking around the subject and help lay the spectre of ‘whistle-blowing’ to rest”.

Throughout this document, we will talk about ‘raising concerns’ or ‘protected disclosures’ rather than ‘whistleblowing’ because the latter has come to denote a sudden, drastic or last resort act.

A ‘protected disclosure’ is the statutory term for whistleblowing; the protection is afforded to the practitioner in the interest of the public.

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1 The Older Peoples Commissioner for Wales (December 2012) Raising concerns in the workplace
The Evidence and Setting the Scene

On 6 February 2013 Robert Francis QC published his much anticipated report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, making nearly 300 recommendations.\(^2\)

The report argued for “fundamental change” in the culture of the NHS to make sure that patients were put first. It was clear that many patients had been let down by a culture that put cost-cutting and target-chasing ahead of the quality of care. The Francis Report starkly portrayed the catastrophic effects when concerns are not raised or dealt with effectively. It is clear that many of the themes carry huge resonance with front-line clinical staff working in the NHS in Wales.

BMA Welsh Council has been discussing the implications of the Francis Report and how best to support those who wish to raise concerns in the NHS in Wales for some time. We have also considered the numerous reports, inquiries and developments since the publication of Francis.

Professor Don Berwick, the renowned international expert in patient safety, offered a broad review of Francis’ recommendations. Much of his 45-page report focused on the creation of a new culture of openness and transparency. He concluded that the systemic problems that led to the tragedy of Mid Staffordshire, were not isolated to one trust alone and the NHS needed to “adopt a culture of learning”.\(^3\)

Indeed the subsequent Keogh Review confirmed Berwick’s conclusions: the problems at Mid Staffordshire NHS Foundation Trust were not a one-off. Eleven of the fourteen hospitals Sir Bruce Keogh considered were placed in “special measures” for fundamental breaches of care; he also identified major failings at the other three hospitals.\(^4\)

More recently the Andrews Report took issue with the culture of the NHS in Wales and worryingly exposed fundamental breaches of care at two of Wales’ largest hospitals. The report recognised the need to adopt a fresh approach to complaints based on openness, early dispute resolution and mediation. It identified “an apparent failure to act or provide feedback on reports of problems and incidents.”\(^5\)

The Andrews Review Team also reported that “people waited for months in some cases for an acknowledgement [of their complaint] and some lost the will to pursue the problem long before the system responded to them…. Delay, prevarication and misinformation seemed to lead in the end to either the aggrieved person giving up or to them becoming so angry that they became litigious or vexatious… Those complaining were upset in large part about the way that their complaint had been handled. It is clear that complaints management was slower and more cumbersome than anyone would expect.”\(^6\)

From the experiences reported by our members, we can say with confidence that this example is replicated for both patients and staff many times across Wales.

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\(^2\) Sir Robert Francis QC (February 2013) Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009

\(^3\) Prof Berwick (August 2013) A promise to learn – a commitment to act Improving the Safety of Patients in England

\(^4\) Prof Sir Bruce Keogh KBE (July 2013) Review into the quality of care and treatment provided by 14 hospital trusts in England

\(^5\) Professor June Andrews and Mark Butler (May 2014) Trusted to Care An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board
The independent Evans Review into the way complaints and concerns are handled in the NHS in Wales – led by Keith Evans, the former Chief Executive and Managing Director of Panasonic UK and Ireland who published his report ‘Using the Gift of Complaints’. This significantly reinforces many of the observations made by doctors – for instance the need for a “no blame culture” and for organisations to learn lessons from complaints. It also said that the process of reporting concerns needs to be promoted and applied consistently across Wales and that some bodies and individuals must learn “how not to be defensive”.

The National Assembly for Wales’ Health and Social Care Committee has recently completed an inquiry into the NHS Complaints Process in Wales. We were particularly pleased to note that the Committee acknowledged the strength of BMA evidence by incorporating many of our suggestions in their recommendations. We currently await the Minister’s response to those recommendations.

In addition to other evidence and high profile reports such as Clwyd & Hart Francis, Berwick, Keogh, Andrews and now the Evans Reports have all pointed to the fact that a non-listening culture is a widespread problem across NHS institutions and poses a significant threat to patient safety.

This mounting evidence, coupled with the increasing number of individual reports we receive from BMA members working in NHS Wales has led BMA Welsh Council to seriously question the sustainability of NHS Services in Wales.

It is our view that strong patient-centred leadership from the highest levels of government and from engaged and empowered clinicians is required if we are to begin to address these serious and endemic – all be they well recognised – problems. A failure to act now may well condemn NHS Wales to repeat these failings in the future.

BMA Cymru Wales is now persuaded that the first step in working towards that is to gain a detailed understanding of the current and future sustainability of all NHS services in every area of Wales.

Our principal recommendation is therefore to:

Call for the Welsh Government to commission a full-scale independent inquiry into all NHS health services throughout Wales

Further details are provided on pages 14-15.

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6 Keith Evans (June 2014) A review of concerns (complaints) handling in NHS Wales “Using the Gift of Complaints”.

Raising Concerns about NHS services in Wales

We know that for the majority of people their experience of NHS Wales is positive, and that as a unique public institution people remain proud of the NHS, its staff and the values upon which it was founded.

Nevertheless, serious concerns over poor performance in many areas – particularly over waiting times and emergency care – have been further compounded by the revealing and worrying reports, already mentioned, which outlined fundamental breaches of care and told us that, when things do go wrong, patients, relatives and staff often feel unable to speak out or are not listened to when they do so.

The current arrangements for raising concerns do little to reassure doctors that they can voice a concern without reproach – and we wonder how many doctors and other NHS employees think twice about speaking out because of this.

In our view the all-Wales Whistle-blowing policy fundamentally sets a tone that is defensive and unnecessarily bureaucratic in process, whilst doing little to encourage either openness or transparency.

One difficulty that doctors report to us is confusion about the mechanism they should use to raise their concerns, given the blurring of responsibility within many organisations about whose individual responsibility it is to deal with a problem.

“The lack of a dynamic process, that takes real ownership and responsibility for an informal or formal concern, must be corrected – as must the absence of any clear leadership in this area. This must cross all aspects of health and social care and provide continued support to concern raisers, including giving considered feedback.”

Dr Phil Banfield, Chair, BMA Welsh Council

The appraisal system, in which all doctors in Wales participate, allows for concerns and complaints raised by doctors to be collated anonymously. Such information should be better embraced by Health Boards, it could for instance be considered at Board level and clear action plans agreed to address the specific concerns identified.

In primary care settings, professionals can give valuable insights to and reflect on the processes for accessing health services, but are wholly under-utilised in this regard. In a recent survey for Pulse (a leading monthly GP publication), nearly a third of GPs who complained about their local hospital’s care of patients found that their concerns were not acted upon. 7

The current processes seem to prevent appropriate engagement between patients, professionals and managers. This creates significant division – supporting a ‘them and us’ mentality – and does little to promote local resolution or ownership. Although we have been supportive of the Welsh Government’s ‘Putting Things Right’ policy we believe that it no longer adequately recognises the interplay between patient and professional concerns.

“It is apparent that many organisations have become stuck in mediocrity; that staff have been isolated, ignored and disengaged; that this behaviour to an extent has become habitual. A non-listening culture, which tolerates poor quality, care has prevailed, to the detriment of good patient care.”

Dr Richard Lewis, BMA Welsh Secretary

At Health Board level there appears to be very little willingness to acknowledge the issues, learn lessons and introduce necessary long-term improvements. In part, this unfortunately reflects the pressure placed on an overstretched workforce to meet short term financial and organisational targets rather than clinically derived ones.

Within many organisations complaints teams are often at the sidelines and not readily accessible to staff or to patients, and our members report that no one seems to have responsibility for championing complaints at executive or board level. The Evans Report has reflected very similar concerns.
What BMA Members Tell Us

We know that doctors and other healthcare professionals can sometimes be fearful about reporting concerns and are worried about the implications of doing so for their professional practice and their ongoing relationships with management and other colleagues.

Many of our members who have raised concerns tell us that when they did so there was a sense of their employer defensively ‘closing ranks’ as soon as an issue was raised, leading to considerable feelings of isolation. Some have also referred to incidences where they have been threatened or intimidated, or subjected to campaigns to discredit their careers or reputations.

Doctors also report that increasing pressures on their time from staff shortages can prevent them from considering such concerns to the extent that they would wish to.

Indeed, many doctors report overwhelming feelings of disempowerment and isolation, saying that they feel unable to pursue their concerns or to press effectively for change when the organisation operates in a ‘state of denial’.

This creates a considerable barrier to service improvement and to ensuring patient safety; it is something that needs to be addressed as a matter of urgency.

BMA Cymru Wales’ view is that no one should be victimised for raising a genuine concern. This means that continued employment and opportunities for future promotion or training should not be prejudiced because a legitimate concern has been raised.

As both a professional association and a trade union, BMA Cymru Wales, will support any member who faces difficulties for having raised a concern in the workplace. Pages 20-21 of this booklet provide further information for doctors on how to access BMA advice and support.

We want to move rapidly towards an NHS in Wales that is open and transparent about patient safety which enjoys a culture of both professional and patient engagement, and empowers all NHS staff to raise concerns without fear of reprisal.

This booklet will be used as the basis for our campaign to bring about the necessary organisational change in every part of NHS Wales.
Concerns in the workplace can vary in nature but they will all have one common factor: ensuring patient safety is not compromised.

Doctors have a specific and clear professional duty to speak out if they feel patient care is compromised. The General Medical Councils’ “Good Medical Practice”\(^8\) requires doctors to always act with honesty and integrity (paragraphs 65-71) and to put matters right if patients have suffered harm or distress.

Doctors accept that, as professionals and as leaders, they have a responsibility and a pivotal role to play in ensuring that all concerns they raise (or are raised with them) are taken seriously and acted upon. Despite this, we know that doctors can be fearful about raising concerns and worried about the personal repercussions of doing so.

Those doctors who are still completing their professional training, often referred to as Junior doctors, have a unique perspective to offer, through their experiences in a variety of patient care settings over the course of a short period of time. The GMC UK has launched a number of investigations arising out of their annual trainees’ survey. However Junior doctors, more than any other branch of medical practice, are fearful about the potential consequences for their career by speaking out.

In order to enable staff to openly and regularly report concerns without fear, it is clear that much needs to be done to facilitate real and genuine cultural change in NHS Wales.

All doctors, backed by their professional code, can be key players in leading this crucial change in attitude.
A Matter of Good Governance

BMA Cymru Wales believes that effective professional practice in NHS Wales should be based on a culture of openness; underpinned by feedback, debriefing and reporting such that these components are seen as a normal, routine and everyday part of clinical governance – not just as a matter of compliance or as an ‘add on’. This should prompt individuals, teams and organisations in NHS Wales to strive for continual improvement. This has to be supported by effective appraisal, revalidation and remediation, based on shared commitment and individual responsibility.

Many issues have the potential to be resolved locally – by informal discussion between the concerned employee and their line manager, so every effort should be made to do so. Often the lack of timeliness and effectiveness by which local procedures respond to and deal with local concerns prevents this, it can leave staff feeling frustrated, disillusioned and professionally exposed.

Furthermore, a failure to encourage improvement through feedback, communication and rapid conflict resolution can lead to the unnecessary escalation of low level concerns and resentment to a level that is destructive to team working and to patient safety.

Better and more consistent application of best practice in managing and dealing with concerns at a local level, founded on robust and consistent governance processes, would provide doctors and other health care professionals with greater confidence when raising and responding to concerns.
The Future: What are we aiming for?

“Doctors, and other healthcare professionals, working in Wales should be able to raise concerns and complaints freely and without fear, with the expectation that questions asked will be answered.”
Dr Charlotte Jones, Chair, General Practice Committee Wales

“Information about performance and outcomes should be shared routinely with staff, patients and the public.”
Dr Michael Thomas, Chair, BMA Welsh Committee of Public Health Medicine

“The disconnect between managers and frontline staff is a major issue, and compounded by significantly overstretched services. It is inevitable that patient safety would improve (and therefore complaints be reduced) if the NHS functioned more effectively.”
Dr Sharon Blackford, Chair, BMA Welsh Consultants Committee

The need for a renewed policy is clear – it must seek to overcome an organisational culture that fails to listen to its clinical staff, and operates a process that is cumbersome and ineffective. Yet a renewed policy is no more than a first step on the path towards organisational renewal.

The question arises as to whether the open and transparent culture we seek is achievable in NHS Wales. Morale amongst the medical profession is at an all time low and the prevailing culture arguably reinforces a passive acceptance of poor quality and low standards of care across NHS Wales. The Andrews Report referred to “a sense of hopelessness and learned helplessness” – it said that the variation in care they discovered resulted in part from “an apparent failure to act or provide feedback on reports of problems and incidents”. 9

It is widely recognised that individual medical and other health professionals are dedicated to delivering the best care possible to patients and that they work tirelessly to do so. It is often the system in which they operate that is flawed and/or dysfunctional.

The current ‘defensive’ culture that discourages the raising of concerns – and then not listening to those which are raised is deeply embedded. Inevitably, it will take real commitment and sustained effort – at both an organisational and individual level – to bring about the positive cultural change so desperately needed.

Often it is the way in which a complaint is handled which causes a breakdown in trust between complaints and ‘the system’. BMA Cymru Wales believes that a fundamental change in attitude towards reporting concerns, including being honest about errors or poor care, is essential. In this, we have much to learn from safety analysis in other sectors and high risk environments, such as the nuclear industry, aerospace and even automobile manufacturing.10

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9 Professor June Andrews and Mark Butler (May 2014) Trusted to Care An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board p2-3
Many patients, relatives and staff may not have the requisite knowledge to appreciate when something is wrong, but they should be encouraged to ask questions about their care (or a relative’s) if they feel concerned that something may have occurred or is not right. It is unhelpful for NHS organisations to react defensively by insisting that detailed formal complaints are made, through cumbersome and unresponsive processes. A more positive approach would encourage patients to question aspects of their care more freely and permit a sensitive response by an empowered organisation.

Accurate, useful and relevant information on the performance of local health services should be made more readily available and accessible to professionals and patients. Good and bad performance should be shared and lessons learned. Local and national data collection systems that capture concerns made about services requires significant improvement. Patients should also have a greater role in informing leadership at the highest levels – for instance by playing a part in hospital inspections.

Future investigations need to look at systems failures including clinical governance arrangements, and not just clinical errors: overstretched services, insufficient staffing levels, poor communication and overworked employees are often reasons for patient dissatisfaction.

Any clinician involved in an adverse event or concern should expect to be supported to explore and understand what has happened, why and how to prevent or mitigate such risks in the future. There may be an educational or remedial need identified that the employer should have an obligation to fulfil, which should be recorded and monitored through relevant processes and annual appraisal. Organisational learning and accountability is a vital part of ensuring continual improvement.

Our proposals are by no means exhaustive – rather they are a specific product of one of BMA Welsh Council’s policy days. They are intended to spark debate at a national level and are a means by which doctors, both individually and collectively, can press for positive change across NHS Wales in every service and at every location where care is delivered. Our aim is to move NHS Wales to a more sustainable future, enabling safer and improved care of patients.
KEY RECOMMENDATION 1

The Welsh Government should commission an urgent and full-scale independent Wales-wide inquiry into all NHS health services throughout Wales.

We believe that in order for the inquiry to provide a robust picture of the sustainability of NHS services it should adapt, as a minimum, the eight ambitions identified in the Keogh Review and use these to formulate key questions to be used by the team inquiring into NHS Wales – these are listed in Table 1 on page 15.

The inquiry should undertake a root cause analysis of the factors that led, or have the potential to lead to fundamental breaches of care. Its terms of reference should also specifically task it to consider:

• Safe and minimum staffing levels across primary, secondary and community care;

• Leadership within Health Boards and Trusts including clinical and patient engagement and the current lines of reporting and accountability for those responsible for dealing with concerns;

• Support arrangements for concern raisers and ‘whistleblowers’;

• The clinical impact of pressures to hit financial and organisational targets;

• The effectiveness of the interface between primary and secondary care;

• Opportunities for learning and improvement from complaints are identified.
TABLE 1
Adapting the Keogh Review ambitions to explore the sustainability of the NHS in Wales.

<table>
<thead>
<tr>
<th>KEOGH AMBITIONS</th>
<th>ADAPTED AS KEY QUESTIONS FOR NHS WALES</th>
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<tbody>
<tr>
<td>1 Reduce avoidable deaths with early warning systems for deteriorating patients</td>
<td>Are existing early warning systems in NHS Wales comprehensive and reliable enough to identify potentially risky environments or practices and to reduce avoidable deaths?</td>
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<td>and introduce more accurate statistical measurement of mortality rates.</td>
<td>Are escalation procedures clinically appropriate?</td>
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<td>2 Expertise and data on how to deliver high quality care to be more effectively</td>
<td>How is data on best practice in NHS Wales collected and shared?</td>
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<td>shared between NHS trusts.</td>
<td>How is it used to drive quality improvement?</td>
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<td>3 Patients, carers and the public should be more involved, and should be able</td>
<td>How is patient experience used to drive quality improvement in NHS Wales?</td>
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<td>to give real-time feedback.</td>
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<td>4 Patients should have more confidence in the regulator the Care Quality</td>
<td>How can patient, staff and public participation in the regulatory work of Healthcare Inspectorate</td>
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<td>Commission, with wider participation of patients, nurses, and junior doctors</td>
<td>Wales be improved to ensure that it commands the confidence of these stakeholders across Wales?</td>
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<td>on review teams.</td>
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<td>5 Hospitals in remote areas should not be left isolated, with staff from better-</td>
<td>How do NHS organisations across Wales access the best in academic, clinical, and management thinking?</td>
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<td>performing hospitals used to train and inspect others.</td>
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<td>6 Nurse staffing levels and mix of skills should be appropriate to the patients</td>
<td>How are nurse staffing levels and their mix of skills assessed as appropriate to the needs of</td>
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<td>being cared for on any given ward.</td>
<td>patients being cared for on any given ward or other care setting?</td>
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<td>7 Medical directors should “tap into the latent energy of junior doctors” and</td>
<td>How do NHS organisations across Wales offer sufficient training and career options to attract and</td>
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<td>include them in review panels.</td>
<td>retain adequate numbers of junior doctors?</td>
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<td>8 NHS employers should make efforts to ensure staff are “happy and engaged”</td>
<td>How are the views of junior doctors sought and considered in the design and delivery of services</td>
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<td>across every part of the NHS?</td>
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<td>How are staff supported to raise concerns on any aspect of patient care?</td>
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RECOMMENDATION 2

The Welsh Government and NHS Wales should engage with NHS professions and their relevant representative organisations, to replace the current ‘whistleblowing’ policy – and make its successor a central and visible component of a positive NHS Wales culture through the creation of a **Raising Concerns Charter** that is regularly renewed.

To enable this change in culture, the Charter should provide a supportive and encouraging backdrop to ensure that concerns are welcomed and seen as opportunities to both improve services and safeguard patients. It should clearly encourage staff to report incidents, discourage the victimisation or intimidation of the concern raiser and outline how such episodes will be dealt with – in line with the Public Interest Disclosure Act 1998 (as amended, see p17).

The Raising Concerns Charter should apply in all settings where NHS care is delivered.

BMA Cymru Wales believes that the Charter should commit Health Boards and Trusts to:

- Clearly define and publicise the processes for handling concerns (whether from staff or patients), and name the post-holder responsible for responding to the concerns. It will integrate as far as possible the procedures for Putting Things Right with those for how staff raise to concerns;

- Clearly set out the timescales for the investigation of a complaint, including the types of communication and feedback a concern raiser will receive;

- Ensure that the Complaints Team will be a central and visible part of the organisation;

- Create the Board level position of ‘Complaints Champion’ to lead the complaints team, whose primary role will be to lead and report on investigations into any concerns raised about standards of care and patient safety;

- Guarantee that new staff will be given an explanation of their employer’s ‘whistleblowing’ policy and complaints processes and the complaints team will be charged to explain these as part of induction procedures;

- Ensure proper engagement between managers and healthcare professionals at all levels across primary, secondary and community settings. 360 degree feedback will form part of the performance management processes for NHS managers;

- Train each NHS employee in how to give and receive feedback;

- Include a standard question, to be asked during employee appraisals, about their knowledge and reporting of any system failures;

- Collect and categorise data on complaints received (from staff and patients) using a traffic light system for showing the severity of the concern. This will be considered at each meeting of the Health Board/Trust Board, and any actions required will be agreed. It will be reported nationally for data monitoring purposes;
• Commit to undertaking a root-cause-analysis of system failures (which do or could potentially compromise patient safety) to be conducted by the Complaints Team, and subsequently report findings at Board meetings;

The Charter will be routinely reviewed with staff and patient representatives.

The separate NHS Wales Staff Survey should include a range of questions (agreed with the professions) to monitor and capture the views of staff on raising concerns in their organisation, and of their experiences of doing so. The survey should be applied consistently across organisations at regular intervals. The results should be used to update the Charter and become part of a wider area of work to monitor cultural change in NHS Wales.

The Raising Concerns Charter will be well publicised and available in hard copy throughout each NHS care setting – as well as available electronically from each organisation’s website.
KEY RECOMMENDATION 3

Healthcare Inspectorate Wales (HIW) should be reformed so as to make it as independent as possible while strengthening its remit and functions. It should have very clear objectives.

It should enjoy an equivalent status to the NHS Counter Fraud Service and be no less well resourced. It needs to attain and maintain the confidence of all healthcare professionals and the general public – and in this way positively, and where possible collaboratively, contribute to the continual improvement of healthcare services in Wales.

We believe that the following measures would assist in the delivery of those aims:

• An independent “Care Quality Assurance Team” shall be created within HIW to act as an independent intermediary between the person (staff, patient or relative) reporting a concern and the range of statutory, professional and other bodies to which a concern may be referred, such that there shall be no expectation on the person reporting the concern to identify appropriate body or mechanism to report such a concern;

• A confidential helpline for advice should be established, operated (24/7) by an independent entity on behalf of the “Care Quality Assurance Team”;

• The “Care Quality Assurance Team” shall submit to the Minister for Health & Social Services:
  a. An annual report on its work; and
  b. Recommendations for improvement/correction arising from individual investigations, where there are wider implications.

• Each NHS organisation shall have a Complaints Champion who will report any concerns received pertaining to that setting to the “Care Quality Assurance Team” to support intelligence gathering and quality assurance.

We consider this to be compatible with the similar concept of an independent national complaints regulator for NHS Wales as suggested in the Evans Report.
A note on Gagging Clauses, Settlement Agreements and PIDA

It is common practice that, as a solution to an ongoing dispute between an employee and an employer in which one leaves the place of work, a settlement agreement (formerly known as a compromise agreement) is drawn up between the two parties.

These agreements also normally contain confidentiality clauses to prohibit disclosure of either the terms of the agreement, or information of a personal or sensitive nature. Such clauses are widespread in settlement agreements within all types of workplaces and are mutually beneficial to all parties.

A gagging clause goes further and attempts to prevent someone from raising a protected disclosure.

The House of Commons Public Accounts Committee published a report in January 2014 on Confidentiality Clauses and Special Severance Payments\(^\text{11}\) – criticising the use of these agreements to terminate employment contracts, especially where confidentiality clauses might prevent doctors or other staff raising patient safety concerns.

Whilst sometimes there is no sensible alternative to a compromise agreement – with or without a confidentiality clause – when relations between employee and employers have broken down, the problems occur when a confidentiality clause is used to prevent an employee from speaking out about safety concerns.

The BMA’s established policy on gagging clauses is that they should be prohibited in the policies, employment contracts, and independent contractor contracts of all NHS organisations; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

The Public Interest Disclosure Act (PIDA)\(^\text{12}\) was introduced in 1998 to protect those employees who raise a concern.

The UK Government recently made a number of amendments to PIDA through sections 17-20 of the Enterprise and Regulatory Reform Act 2013:

- Section 17 narrows the definition of ‘protected disclosure’ to those that are made in the ‘public interest’.
- Section 18 removes the requirement that a worker or employee must make a protected disclosure ‘in good faith’. Instead, tribunals will have the power to reduce compensation by up to 25% for detriment or dismissal relating to a protected disclosure that was not made in good faith.
- Section 19 introduces protection for whistleblowers from bullying or harassment by co-workers.
- Section 20 enables the Secretary of State to extend the meaning of ‘worker’ for the purpose of defining who comes within the remit of the whistleblowing provisions.

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These important amendments mean that the wider definition of ‘worker’ now covers GPs performing services under a variety of different contracts (not just GMS contracts) made with a Local Health Board under the National Health Service (Wales) Act 2006. Therefore the protection from detriment and dismissal for whistleblowers introduced by the Public Interest Disclosure Act 1998 into the Employment Rights Act 1996 also applies to GPs.

Whilst it is important to have a robust framework in place, the matter of how this framework is applied locally is key to improving the experiences of those who raise concerns and bringing about a more open culture.
Further Information for Doctors in Wales

The BMA Principles on Raising Concerns

For those who wish to raise a concern it is important to understand when to act, as well as the practical steps to take in order to do so.

The general principles upon which we provide advice to BMA members regarding raising a concern are:

• Everyone should be aware of the importance of preventing and eliminating wrongdoing at work. You should be watchful for illegal or unethical conduct and report anything of that nature that you become aware of.
• Any matter raised should be investigated thoroughly, promptly and confidentially, and the outcome of the investigation reported back to the concern raiser.
• No one should be victimised for raising a concern. This means that the continued employment and opportunities for future promotion or training of the concern raiser should not be prejudiced because they have raised a legitimate concern.
• Anyone victimised after having made a disclosure under the Public Interest Disclosure Act (PIDA) 1998 can bring a claim at an Employment Tribunal. Each employer should treat any acts of victimisation as a disciplinary offence.
• An instruction to cover up wrongdoing is itself a disciplinary offence. Anyone told not to raise or pursue any concern, even by a person in authority such as a manager, should not agree to remain silent. She should report the matter following the steps outlined in the BMA’s online guidance.
• Any BMA Member asked to sign a compromise agreement or another type of agreement about which they have concerns should seek advice from the BMA before signing. Alternatively they should consult a solicitor.
• Deliberately making a false allegation may be a disciplinary offence.

What About the Contract?

For Doctors employed on a nationally agreed contract of employment or terms of conditions of service, the following express term of paragraph 330 from the national ‘Hospital Medical and Dental Terms and Conditions of Service (England and Wales)’ should feature in the contract:

“A practitioner shall be free, without prior consent of the employing authority, to publish books, articles etc., and to deliver any lecture or speak, whether on matters arising out of his or her NHS service or not.”

The BMA interprets this to mean that in addition to the protections afforded to individuals raising concerns under the Public Interest Disclosure Act (PIDA) 1998, the contract also entitles doctors to speak freely. The PIDA gives statutory protection to employees who disclose information reasonably and responsibly in the public interest and who are victimised or even dismissed as a result. Please note that the terms of a settlement agreement override those of the applicable national contract.

Further information and guidance is available on the BMA website bma.org.uk
Get in Touch

For initial guidance you can call the BMA (UK) on 0300 123 1233. If there is particular support we need to provide locally, you will be transferred to a relevant adviser in Wales.

You can also email us on: support@bma.org.uk.

Doctors for Doctors, (telephone 08459 200 169) is the BMA counselling service for doctors and students, which can offer support for the emotional aspect of the dispute you may be going through.

Get Involved

Experience shows that medical staff acting together in the best tradition of trade unionism remain a powerful and influential force through which much can be achieved at a local and national level.

Make sure you are part of it.

To join the BMA call our Membership Team on 020 7383 6955 during office hours (Monday to Friday 9.00am – 5.00pm) or email membership@bma.org.uk. Alternatively, join online at www.bma.org.uk

There are a number of ways to for you to get involved with their local BMA:

• Every BMA member in Wales belongs to one of eight Divisions which represent members in all disciplines geographically. BMA Divisions provide an opportunity for members to discuss issues that impact on all branches of practice and to debate local matters with other members in the area. Divisions also submit motions to the Annual Representative Meeting (ARM) which if passed become national BMA policy.

• BMA Cymru Wales also has established a network of Local Negotiating Committees (LNCs) in NHS Health Boards and Trusts throughout Wales. These committees ensure that the voice of the medical profession is heard by management in the workplace and that the interests of doctors are protected in negotiations on terms and conditions of service.

• There are also five Local Medical Committees (LMCs) across Wales which represent GPs in particular areas. LMCs contribute to the wider activities of BMA Wales but are not BMA Committees, rather they are independent statutory bodies with which Health Boards (as holders of the GMS contract) must consult. LMCs also offer professional advice to Health Boards, NHS bodies and local GPs. Members of the LMC are elected by local GPs.
To get involved in your local BMA Division, Local Negotiating Committee or Local Medical Committee please contact BMA Cymru Wales:

BMA Cymru Wales
5th Floor, 2 Caspian Point,
Caspian Way,
Cardiff Bay,
CF10 4DQ.

T: 029 2047 4646
E: bmawales@bma.org.uk

Blog – blogs.bma.org.uk/cymruwales/
Twitter – twitter.com/BMACymru
YouTube – youtube.com/user/bmacymrutv
Flickr – flickr.com/photos/bmacymruwales