This has been published as:

Lewis, D. & Vandekerckhove, W. (2015). Does following a whistleblowing procedure make a difference? The evidence from the research conducted for the Francis Inquiry. In Lewis, D. & Vandekerckhove, W. (eds) *Developments in Whistleblowing Research 2015*, pp. 85-105. London: International Whistleblowing Research Network.

7. Does Following A Whistleblowing Procedure Make A Difference? The Evidence From The Research Conducted For The Francis Inquiry.

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Although the following definition does not match statutory ones in the UK or elsewhere, researchers frequently rely on it: "The disclosure by organisation members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organisations that may be able to effect action" (Near & Miceli,1985: 4). Using this formulation academics in the US and elsewhere have been conducting empirical studies of whistleblowing and whistleblowers for over three decades (Brown et al., 2014). For example, in the UK surveys have been conducted in schools, further and higher education, local government and the National Health Service (see Lewis, 2006) as well as the FTSE Top 250 firms (Lewis & Kender, 2010).In Australia, a major study in 2006 surveyed 7763 employees from 118 public sector organisations (Brown, 2008). More recently, the UK whistleblowing charity Public Concern at Work and the University of Greenwich published a study of the experiences of 1000 callers to the charity's helpline (PCAW & University of Greenwich 2013).

In June 2014 the Secretary of State for Health, Jeremy Hunt, appointed Sir Robert Francis Q.C.to chair an independent review into creating an open and honest reporting culture in the NHS. The Review was established in response to ongoing disquiet about the manner in which health service employers dealt with whistleblowers and the concerns they raised. In recent years, unsafe treatment and care had been exposed but there was evidence that NHS staff felt unable to speak out or were ignored when they did (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). As part of the Francis review (Francis, 2015), the authors were commissioned in 2014 to a) establish a confidential online system for collecting data through surveys, b) to conduct document analyses, and c) interviews.

In this chapter we present our findings in relation to the question: does following a whistleblowing policy/procedure make a difference for the whistleblowing outcome? We first set out the data collection methods used for the surveys, document analysis, and the

interviews. This is followed by a section indicating limitations of the methods and samples. We start reporting findings from section three onwards, beginning with results from the document analysis on the nature and content of whistleblowing policies and procedures. We also present our survey findings on this in section three. In the sections after that, we present our results from the different methods in a triangulating way rather than separately. Hence except for section three, we present the survey results and use findings from the document analysis and the interviews to validate our interpretations. Section four looks at types of concerns, section five at outcomes and management of concerns, and section six at fear and experience of victimization. We then focus on two aspects of the process of using the procedures: availability of advice for whistleblowers (section seven) and the involvement of trade unions (section eight). Finally we draw some conclusions in section nine.

Research Methodology

In August and September that year surveys were conducted of workers in NHS primary and secondary care settings and NHS Trusts. Mechanisms do not exist to communicate directly with each individual member of NHS staff or individual persons working in GP practices and community pharmacies. As a result, these surveys could never be a comprehensive survey but instead aimed to give a flavour of the experiences and views of a sample of staff. For the trust staff it was necessary to use a cascade mechanism set up by NHS England to publicise the survey. NHS England arranged for the NHS Trust Development Authority & Monitor to distribute letters to the CEOs of each trust. It was then left to each CEO (or their team) to determine how best to publicise and disseminate the survey within their organisation, for example, an email to all staff, link in a bulletin, publicity on the intranet etc. An informal telephone check suggests that this mechanism is, at best, variable, with some Trusts using multiple routes to publicise the survey, some adopting one approach and others taking no known action. 15,120 people responded to this survey. However, it is not possible to provide a response rate as there was is no baseline figure for recipients.

In relation to primary care staff, members of the review team sent details of the survey to all Clinical Commissioning Groups and asked that they forward the information to all GP practice managers in their area. They also asked the General Pharmaceutical Council (GPhC) to send details of the survey to all registered pharmacy professionals working in England. 4644 responded to the survey. To our knowledge, these surveys constitute the largest ever piece of research on staff experiences and views about raising concerns.

60 trusts submitted responses, which is a quarter of English trusts. More than one person from some trusts provided responses to the survey. Indeed, overall 411 responses were sent on behalf of trusts and the findings below are based on the number of responses rather than the number of trusts. Although the results may not be representative of trusts generally, there has been a sufficient number of responses to provide a useful picture of how whistleblowing

and whistleblowers are being handled in this sector. All the surveys were completely anonymous.

In relation to the document analysis, a ranking of 233 Trusts was compiled by the Review Team based on results from seven questions from the 2013 staff survey (NHS, 2013) relating to raising concerns, error reporting, bullying, and harassment.[1] Thirty trusts were selected from this list (10 top -third, 10 middle -third, 10 bottom -third, randomly).

These were asked to send their whistleblowing policy and procedure, which were often in one document. The Review Team received 21 whistleblowing policies/ procedures: 6 top, 7 middle, 8 bottom. A framework of 17 items was used.[2] These were derived from the analysis of international whistleblowing guidelines (Vandekerckhove and Lewis, 2012) and from the whistleblowing Code of Practice produced by the Whistleblowing Commission for Public Concern at Work in 2013. We think the fact that most of these items overlapped increases the validity of the framework.

In relation to the interviews, a first call for participants was made through the Freedom to Speak Up website which allowed people to put themselves forward. The call was open to everyone working in the NHS i.e. those working both in Trusts and in primary care. The call was administered by Mencap, independently from the Review Team. The call was open from 20 July-15 August 2014 and there were 29 respondents. From these, 22 participants were selected based on their role in the whistleblowing process and the type of Trust they worked in. A second call was then made by Mencap, targeting HR managers and Directors from the 30 Trusts selected for the policy review. This resulted in 9 additional participants. Finally, we completed our sample composition through 'snowballing'[3] 11 additional participants. In total we selected 42 participants but 5 withdrew before the interview took place. This resulted in the following sample (Table 1):

[1] These items were: 1) My organisation encourages us to report errors , 2) My organisation blames or punishes people who are involved in errors, 3) If you were concerned about fraud, malpractice or wrongdoing would you know how to report is, 4) Would you feel safe raising your concern, 5) Would you feel confident that your organisation would address your concern, 6) In the last 12 months how many times have you personally experienced harassment, bullying or abuse from managers or colleagues, 7) The last time you experienced harassment etc did you or a colleague report it?

[2] 1. Who does the policy apply to? 2. What is the scope of concerns that can be raised? 3. Does the policy identify recipients at successive tiers? 4. Is the procedure operated in-house or through an external provider? 5. Does the policy describe the process of what happens with concerns that have been raised? 6. Is the policy clear on confidentiality and anonymity? 7. Is whistleblowing a right or a duty? 8. Are the policies clear on protection and sanctioning reprisals? 9. Does the policy avoid referring to motive? 10. Are whistleblowers rewarded? 11. Are whistleblowers encouraged to seek independent advice? 12. Is there any training provided in relation to the policy? 13. How are concerns registered? 14. How is the policy monitored and who reports on that? 15. Who has overall responsibility for the policy? 16. Are unions and other stakeholders involved in developing and monitoring the policy? 17. Does the policy foresee a review?

[3] 'Snowballing' is the process whereby existing participants suggest additional participants.

Table 1. Composition of interview sample

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

Interviews were conducted using questions based on the three elements of Ajzen's theory of predicted behaviour, as developed in Vandekerckhove, Brown and Tsaharidu (2014): attitudes, social norms, and perceived behavioural control.

Research Limitations

Since people were free to choose whether or not to participate in the surveys the respondents can be described as self-selecting. In large surveys of this nature it is inevitable that some potential respondents will have more interest, knowledge and experience than others. For example, those who have raised a concern (successfully or otherwise) might be more willing to participate than those who have not done so or seen others do so. Additionally, those who have had a bad experience or witnessed others being victimised may be more inclined to report than those who were satisfied with the way their concerns were handled.

However, it is worth noting that the proportion of responses received from staff in particular types of trust is comparable to the returns from the trusts themselves. In addition, it can be seen the profile of respondents to the staff surveys closely reflects that of the health service generally in terms of gender, age, ethnic background and direct contact with patients. However, our survey respondents seem to have longer periods of service than staff generally in the health service. This is not surprising since people with lengthy service may have greater commitment to their employer as well as more experience of the raising and handling of concerns at the workplace.

As regards the document analysis, in the ranking of NHS Trusts based on an aggregated score of selected staff survey questions, we relied on data from 2013. Further analysis should take

into account the upward or downward trend of the particular Trust over the last 3 years. In relation to the interviews, although the sample included many stakeholders of NHS Trust whistleblowing policies, it was not possible to compose 'nested' samples i.e. which would interview different stakeholders of a particular organisation and hence a particular policy/ procedure. Although it seems immensely difficult to accomplish this, further research would benefit from such samples.

The Nature And Content Of Nhs Whistleblowing Procedures And Policies

The Findings From The Document Analysis

The policies included in our sample showed a considerable variation in how elements of the procedure and policy were worded. However, for ease of reference the findings below are set out in accordance with recognisable headings(Vandekerckhove and Rumyantseva, 2014).

To whom does the policy apply?

Whistleblowing policies should make clear that they can be used for all who work at the organisation regardless of their employment status (employee, volunteer, contracted worker, student, etc). The policies in our sample fell into two groups, with one set of policies clearly indicating that staff includes agency workers, volunteers, and employees of contractors. Other policies are not clear at all about who they apply to. For example, 'staff' and 'all employees' are interchanged without further description; a policy used the wording 'individuals directly employed by the Trust' throughout the text and only extended this in the last paragraph; a number of policies gave a broad description on the header sheet under 'target audience' but not in the text itself.

What concerns can be raised?

Policies should use a broad category of concerns that are relevant to the type of activities of the organisation. In our sample we saw very good examples of contextualised distinctions between grievances and public interest concerns. One policy had a table giving examples of each, e.g. 'an employee's complaint about the type of work he or she is being asked to do that is not covered by his or her contract' would be a grievance, whereas 'a disclosure that an individual has been instructed to carry out actions that he or she believes to be illegal' is a public interest disclosure; or 'An employee's complaint about the hours that he or she is expected to work' would be a grievance, whereas 'A disclosure that the requirements imposed on a group of staff breach the working time legislation' is a public interest disclosure. Such a contextualised table gives more confidence in a policy than an abstract definition. However, many policies simply adopt PIDA stipulations without any contextualisation. There were also policies in our sample that merely put 'public interest' as a requirement but give no further description of what that is.

Does the policy identify potential recipients at different tiers?

Good policies identify multiple recipients at various hierarchical levels, as well as appropriate external and regulatory recipients. The policies in our sample did identify multiple tiers where staff can raise a concern. Potential recipients at top level include CEO and/or non-executive Directors. All but one also specified external recipients. Some policies included awkward lists, i.e. omitting CQC from recipients, or listing regulators together with advice organisations (without making any distinction). A small number of impressive whistleblowing policies also mentioned the possibility of raising a concern with an MP or the media. However, other policies include a warning against 'rash disclosures' to the media, or even mention media disclosures as unjustified external disclosures.

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

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

Does the policy describe the process by which concerns are handled?

Good policies allow various modes for raising concerns (verbal, written, electronic) and will explain the organisational processes for dealing with concerns that have been raised, i.e. how these are investigated and how communication with whistleblowers proceeds. Most policies in our sample opt for raising concerns verbally with the line manager, but require writing beyond that stage. One policy included a specific form in its appendix. Another two policies left it open as to how staff could raise a concern but required managers to keep a log. The sample showed a huge variety in how concerns are processed.

Is the policy clear about confidentiality and anonymity?

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

Is whistleblowing a right or a duty?

Policies need to strike an appropriate balance between whistleblowing as a right as opposed to a professional duty. The acknowledgement of whistleblowing as a statutory right opens the door to the imposition of whistleblowing as a duty through internal organisational policies (Tsaharidu & Vandekerckhove, 2008). To a certain extent this is even conceptually desirable. However, such a duty risks bringing about unreasonable expectations about employees, e.g. making them liable for not raising a concern in organisational cultures that are unsafe with regard to raising concerns (Vandekerckhove & Tsahuridu, 2010). A small number of policies in our sample were problematic in this regard. For example, one policy stated that raising concerns about patient safety was a professional duty but that this was not allowed if the disclosure itself is a criminal offence. Another example is where raising concerns is described as a responsibility under the title 'duties and responsibilities' but no-one seems to have a responsibility to prevent reprisal.

Are the policies clear about protection and the sanctioning of reprisals?

Policies need to establish the organisational framework to make raising a concern safe. To that end, they need to both guarantee protection from reprisal and explicitly state that reprisals will be sanctioned. Nearly all policies in our sample include a statement that those who raise a concern will not suffer detriment, often stating that reprisals will not be tolerated. However, we favour the stronger, positive wording that reprisals against those who raise a concern will be sanctioned. About half of the policies make no mention of sanctioning reprisals. Two policies used problematic wording. One stipulated that reprisals had to be reported as a grievance, and that disciplinary action would be taken if a concern was raised 'frivolously, maliciously, or for personal gain'. Another stated that one 'should raise concerns without fear' and, although it said reprisals would be sanctioned, it did so in the same sentence as stating that unjustified disclosures would be a disciplinary matter.

Does the policy avoid referring to motive?

One of the recent changes to PIDA was the removal of the 'good faith' test. This followed a consensus amongst whistleblowing scholars (Roberts, 2014) and increasingly also amongst policy- makers[4] that malicious whistleblowing occurs if a person raises a concern that she or he knows to be false. The opposite is raising a concern when one has a reasonable belief that it is true. Motive-tests introduce arbitrariness in whistleblowing protection schemes and are counter-productive. It was striking to see that almost all policies included expressions like 'good faith' and 'genuine concern', which carry strong connotations of motive. Three policies even went as far as explicitly identifying good faith, genuine concern, and honesty as conditions for protection. We also saw policies that worked consistently with the recommended 'reasonable belief', but others introduced confusion by using 'genuine' or 'good faith' in addition to 'reasonable belief'. One policy had an original take on this by stating

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

first using ‘reasonable belief’ but further on stating employees had to raise ‘genuine concerns that you reasonably believe are in the public interest’.

Are whistleblowers rewarded?

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

Are whistleblowers encouraged to seek independent advice?

It is generally assumed that whistleblowers can benefit from independent advice on how to raise a concern so that they are aware of conditions and requirements at the various stages of the process. In our sample, all but two policies gave at least two suggestions where staff could get independent advice on how to raise a concern or use the policy. This always included unions, and either or both the NHS Whistleblowing Helpline (operated by Mencap) or Public Concern at Work. One policy also listed the CQC as an advice line.

Is there any training provided in relation to the policy?

Research suggests that the aspect of whistleblowing which organisations need to develop most is that of appropriately responding to concerns that are raised (Vandekerckhove, Brown, & Tsahuridu, 2014). Although there is no clear norm as to what constitutes effective training for this, the policies in our sample did not give this item a lot of thought, or left unspecified how they see links with leadership training. Four policies mentioned some management training. However, two of these only provided training for designated leads but not for line managers. A number of policies totally omitted to mention training. Three policies said training consisted of policy awareness only. Two of these mentioned this was to be dealt with at induction. Two policies stated ‘training’ means updating information on the intranet, and two policies explicitly stated no specific training was needed. One policy seemed to totally miss the point of training by suggesting it is something done after the fact: ‘Human Resources Business Partners and Senior Managers across the Trust will be responsible for training and education relating to compliance with this policy in the event that an individual need arises’.

How are concerns registered?

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

How is the policy monitored and by whom?

The policies in our sample also showed a huge variety on this item. Monitoring and reporting on how the whistleblowing procedures and policies work is clearly an element that is not thought through or where Trusts lack established practice. One document stated that the whistleblowing policy would be monitored by considering the number of incident reports. Another indicated that it would do this by looking at grievance and employment tribunal data. Yet another said monitoring would be based on the staff survey data. There was also a policy that stated there were indicators, without specifying what these were. On the other hand, there were also some good examples where policies expressly provided that monitoring would be based on the number and nature of the concerns raised, together with other identified indicators measuring organisational culture. Other good practice seen in sample policies was explicitly stating who would report to whom and when. However, one policy stated HR would annually audit itself.

Who has overall responsibility for the policy?

The majority of policies in our sample identified HR (or the Director of Workforce) as having overall responsibility for the policy. Exceptions were: non-executive Director, Chief Nurse, Governance Team, CEO, Director of Corporate Governance & Facilities.

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

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

Does the policy provide for a review?

All policies in our sample mentioned the date of the next policy review. This was nearly always in 3 years' time. However, for two policies it was 2 years, and for one it was 5 years.

The Survey Results

In the light of the longstanding guidance from the Department of Health that trusts should have arrangements in place for whistleblowing, the trusts survey did not ask whether or not trusts had a procedure. However, we did ask who had overall responsibility for their procedure. Of those respondents who knew, 56.6% pointed to the chief executive and 34% to Human Resources. Information was sought about whether the trust has a policy which offers guidance on how to raise a concern about suspected wrongdoing and what protection staff might get if they do so. 78.2% of respondents claimed that such a policy existed. When asked how such a policy was described, the most frequent responses were "whistleblowing policy" (52.8%) and "policy for reporting concerns" (23.2%). We do not believe that the title of a policy or procedure is particularly vital so long as interested persons (especially potential users) can find it. Thus we suggest that intranet search engines in all sectors should also

provide access when people offer any of the following illustrative descriptions: “confidential reporting”, “speak up”, “public interest disclosure” or “protected disclosure” policies.

By way of contrast, we felt it appropriate to see if staff were aware that their trust has a whistleblowing/ confidential reporting etc procedure. 75% of trust staff and 68.8% of primary care staff stated that this was the case. Although these figures might be regarded as acceptable, we believe that any significant level of staff ignorance about whistleblowing procedures is potentially problematic. This view is reinforced by the results discussed below which suggest that following a procedure can have significant advantages (in terms of safety, satisfaction, etc) for both staff and employing organisations.

When asked who could use their procedure, trust respondents identified a wide range of persons. Most frequently mentioned were employees (78% of responses); volunteers (39.1%); agency workers (38.7%); contractors (26.3%); self-employed (20.8%) and sub-contractors (19.7%). It is particularly encouraging to see that access is afforded to groups who would not have statutory protection under Part IVA of the Employment Rights Act 1996 (ERA 1996), for example, volunteers, patients (18.6%)and members of the public (16.1%). It is not only good practice to allow the widest possible access to whistleblowing arrangements but a matter of self-interest. However, the results from the document analysis are in line with the survey finding that only a minority of trusts identify a broad range of persons that can invoke the procedure. If organisations do not encourage the use of their whistleblowing procedure they risk potentially damaging external disclosures or people remaining silent about suspected wrongdoing.

Trusts were asked whether their procedure encourages people to use particular mechanisms for reporting concerns. The most frequently mentioned methods were: oral reports in person (70.8% of responses); paper reports (60.2%); email (51.3%) and telephone (48.7%). This accords with good practice which recognises that people with concerns often wish to report them informally to their line manager at first instance.[5] However, a range of alternatives should be provided in case these are needed or preferred. Our interview data indicates that problems can arise with the transition from informally raising a concern to raising the matter via a formal procedure:

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

[5] See below and BSI (2008)

The NHS Terms and Conditions Handbook stipulates that "all employees working in the NHS have a *contractual right and duty* to raise genuine concerns they have with their employer about malpractice … etc".[6] By way of contrast, the NHS Constitution for England states that "staff *should aim to* raise any genuine concern [they] may have about a risk… at the earliest reasonable opportunity" (DoH, 2013: 15 emphasis added). In the light of these provisions, trusts were asked if their procedure states that people should report concerns about suspected wrongdoing and, if so, what form such an obligation takes. Of the 68.5% of responses offering a view, 92% indicated that people should report a concern. For 43.8% of these this took the form of a duty to report, 35.2% pointed to an expectation that staff will report and 13.3% mentioned a request to report. It is clear that a duty to report may cause serious practical problems. For example, the making of allegations prematurely for fear of being in breach of the obligation to disclose information about suspected wrongdoing and the issue of enforcement by management if it becomes clear that many people have failed to report. Thus we think that it is preferable to indicate to staff that, given the existence of detailed whistleblowing arrangements at the workplace (which include safeguards for those who invoke them, training, feedback etc), there is an expectation that they will be used when appropriate.

The Concerns Raised

35.4% of trust staff and 21.6% of primary care staff respondents indicated that they had raised a concern about suspected wrongdoing in the health service. Table 2 shows the reasons staff gave for not raising a concern.

[6] Section 21.1 (Pay Circular) 4/2014.(emphasis added)

Table 2: Reason for not raising a concern about suspected wrongdoing in the health service among trust and primary care staff

Reason trust staff never raised a concern about suspected wrongdoing	**%**	**Reason primary care staff never raised a concern about suspected wrongdoing**	**%**
You have never had any concern	56.5	You have never had any concern	68.8
You had a concern but you didn't know how to raise it	5.3	You had a concern but you didn't know how to raise it	8.2
You had a concern but you didn't trust the system	17.9	You had a concern but you didn't trust the system	7.5
You had a concern but you feared being victimised	14.8	You had a concern but you feared being victimised	10.4
Other	5.5	Other	5.0
TOTAL	100 (n=8851)	TOTAL	100 (n=3341)

Unsurprisingly, the main reason given was that staff did not have a concern. More troubling are the numbers stating that they did not trust the system, feared victimisation or did not know how to raise a concern.

Staff who had raised a concern were asked whether they had used their employer's whistleblowing/confidential reporting procedure. 36.5% of trust staff and 47.5% of primary care staff respondents indicated that they had. Our interview data suggests that people may only look for whistleblowing procedures once they identify themselves as whistleblowers. However, this might be after they have already raised their concern:

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

Table 3 reveals the reasons staff gave for not using the employer's procedure.

Table 3: Reason for not using the employer's procedure when raising a concern among trust and primary care staff

Reason for trust staff not using employer's procedure when raising a concern	**%**	**Reason for primary care staff not using employer's procedure when raising a concern**	**%**
Did not know how to use the procedure	12.1	Did not know how to use the procedure	9.3
Had a reason not to use the procedure	33.3	Had a reason not to use the procedure	37.1
Some other reason	54.5	Some other reason	53.6
TOTAL	100 (n=2357)	TOTAL	100 (n=321)

Those who had raised a concern were also asked on how many occasions they had done so in the last five years. Trust staff most frequently stated 2-3 occasions (41.7%) and primary care respondents most frequently indicated that a concern had been raised on one occasion (39.1%). In both surveys those using the relevant procedure were more likely to have raised concerns one or more times than those not using the procedure or not knowing whether one existed.

66.9% of responses from trusts indicated that people should initially report a concern to the line manager. As regards alternatives if needed, 37% of respondents referred to the Head of Department, 24.1% to a person designated by the trust to receive concerns, 23.7% mentioned Human Resources and 18.4% suggested that it depended on the concern or circumstances. Staff who had raised a concern were asked with whom they first raised it. 96.6% of trust staff and 79.7% of primary care staff indicated that they had raised their most recent concern internally. Consistent with the data from trusts discussed above, Table 4 shows that a majority of staff respondents indicated that they first raised a concern with line managers.

Table 4: With whom trust and primary care staff first raised a concern

With whom staff first raised a concern	% among trust staff	% among primary care staff
Datix	6.6	n/a
Line Manager informally	52.3	49.4
Line Manager in writing	7.3	5.4
Head of Department	9.9	n/a
Chief Executive	2.0	1.9
Head/Chair of Audit Committee	0.0	n/a
Clinical director	1.5	n/a
Human Resources	4.9	3.1
Senior Partner	n/a	7.9
Internal Hotline	0.1	0.3
Chair of Governors	0.3	n/a
Senior manager/leader	n/a	10.0
Incident report form	2.5	4.3
A designated person	2.7	8.5
Other internal	7.6	6.5
Other external	0.2	2.6
TOTAL	100 (n=4303)	100 (n=680)

Interestingly, primary care staff who used the procedure were less likely to raise a concern informally with a line manager first, but more likely to go to a designated person or senior partner than those who did not follow the procedure or were unaware of its existence. When asked if they were satisfied with the response to the concern raised internally, 39.5% of trust staff and 53.1% of primary care respondents said they were satisfied. It is noteworthy that in both surveys those who did not follow or were unsure about the existence of an employer's procedure were least likely to be satisfied.

Overall 38.2% of trust staff and 39.1% of primary care respondents took the matter further within their organisation. Perhaps unsurprisingly, those who did not use or were unsure about the existence of the employer's procedure were less likely to do so. Respondents were asked whether the matter was resolved when the concern was taken further within the organisation: 17.7% of trust staff and 14.6% of primary care respondents stated that the matter was resolved. In the trust staff survey, those who were unsure about the existence of

the employer's procedure were considerably less likely to say that the matter was resolved whereas in the primary care survey those who did not use the procedure were least likely to so indicate.

10.9% of trust staff took their concern outside their organisation and those who used the procedure were most likely to do so. By way of contrast, 42% of primary care respondents went outside the organisation with those who were unaware about the existence of the procedure least likely to go outside. One explanation for these results is that procedures themselves provide for unresolved matters to be raised externally, although the findings from our document analysis differ widely on which external routes are identified. Those who were unaware about the existence of a procedure may have been apprehensive about the possible reaction to an external disclosure. In both staff surveys the main reason given for raising concerns externally was lack of confidence in the internal procedure. Our interview data supports this finding and in particular suggests there is a lack of trust in HR independence and in middle management.

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

No doubt it was with this in mind that the Francis report suggests the establishment of Freedom to speak up guardians. Apart from the practical advantages of having a system of specialist trained recipients of concerns with access to the Board in place, its very existence might suggest to potential whistleblowers that the organisation will take their concerns seriously.

Table 5 shows the external bodies most commonly approached by NHS staff.

Table 5: To whom trust and primary care staff raised their concern externally with

	% among trust staff	% among primary care staff
Professional Body	35.0	53.7
Trade Union	38.0	12.3
MP	7.7	3.7
Health Service Regulator	24.1	32.1
Police	6.2	3.7
Media	1.8	1.9
Public Concern at Work	4.0	3.1
External Hotline	4.0	1.2
Ombudsmen	2.2	2.5
Other	32.1	27.8
TOTAL	100 (n=274)	100 (n=162)

Again, trade unions and professional bodies were more likely to be contacted by those who invoked the employer's procedure than those who did not or were unaware of such a procedure.

The Outcomes And Management Of Concerns

Trusts were asked about the outcome on the most recent occasion their whistleblowing procedure was used. Of the 94 responses, only 1.9% stated that the concern did not merit investigation. 42.3% indicated that there was an investigation but no wrongdoing was identified and exactly the same number said that wrongdoing was identified.[7] 30.8% of responses maintained that the person raising the concern was informed of the outcome and 28.8% stated that such a person was thanked. In terms of who investigates, 42.5% of respondents said that it depends on the concern or circumstances, 32.5% stated that it was the line manager and 25.9% mentioned Human Resources. Staff respondents were asked whether an investigation of their concern was carried out. Overall 42.9% of trust staff and 48.9% of primary care staff indicated that an investigation was conducted. In both surveys those who used the employer's procedure were most likely to indicate that an investigation took place and those who were not aware of the existence of a procedure were least likely. As regards the outcome of the investigation, overall 73.4% of trust staff and 79.4% of primary

[7] The wrongdoing was stated to be dealt with in 21.2% of responses but not dealt with in 3.8% of responses.

care respondents indicated that they were informed about it. In both surveys, those who were not aware of the existence of a procedure were least likely to be told the outcome. 68.1% of trust staff and 75.3% of primary care respondents maintained that wrongdoing was found to have occurred. 82.5% of trust staff and 82% of primary care respondents asserted that the wrongdoing was dealt with. In the trust staff survey, wrongdoing was least likely to be dealt with where the respondent was not aware of the existence of a procedure and in the primary care survey it was least likely to be dealt with where the procedure was not invoked.

The Fear And Experience Of Victimisation

Table 6 shows the detriments incurred by staff after supporting a colleague who raised a concern.

Table 6: Detriment suffered by trust and primary care staff after supporting a colleague who had raised a concern

Type of detriment suffered	% among trust staff	% among primary care staff
Ignored by colleagues	25.4	15.2
Ignored by management	48.2	48.2
Victimised by colleagues	25.6	23.2
Victimised by management	56.3	61.6
Other	13.1	12.8
TOTAL	100 (n=2042)	100 (n=336)

When asked the reason for not raising a concern about suspected wrongdoing in the health service, 14.8% of trust staff and 10.4% of primary care staff respondents said they 'feared being victimised'. As regards the treatment from co–workers and management after raising a concern, 17.3% of trust staff and 16.2% of primary care staff respondents alleged that they were victimised by management. Both trust and primary care staff who used the procedure were noticeably more likely to be praised than those who did not use the procedure or were unaware of its existence.

In relation to the perceived level of safety after raising a concern, more trust staff respondents felt unsafe or very unsafe (30.5%) than safe or very safe (23.1%). Those who were not aware of the existence of a procedure were most likely to feel unsafe or very unsafe and least likely

to feel safe or very safe. 29.4% of primary care staff felt safe or very safe and 24.9% felt unsafe or very unsafe. Those who used their employer's procedure were most likely to feel safe or very safe and those who were not aware of the existence of a procedure were most likely to feel unsafe or very unsafe. Overall 41.8% of trust staff said that they would be highly likely to raise a concern again if they suspected serious wrongdoing, although the figure for those not aware of the existence of a procedure is 29.7%. By way of contrast, 77.6% of primary care staff respondents indicated that they were highly likely or likely to raise a concern again. Those who were not aware of the existence of a procedure most frequently stated that they were unlikely or highly unlikely to raise a concern again (22.7%).

The Availablity And Take-Up Of Advice

Trusts were asked whether their procedure states that independent advice is available to a person reporting a concern or considering doing so. 56.3% of responses were "don't know" but, of those who knew, 60.4% indicated that such advice was available. Staff were asked whether they took advice before raising a concern and, if so, from whom. 44.5% of trust staff and 44.7% of primary care staff respondents indicated that they took advice. In both staff surveys, those who used their employer's procedure were noticeably more likely to have taken advice than those who did not use the procedure and those who were unaware that one existed. Trust staff were most likely to obtain advice from a work colleague (70.5%), a trade union (28.2%) or a professional body (16.9%). Trade unions, professional bodies and both internal and external helplines were most likely to be the sources of advice when the procedure had been invoked. Our document analysis showed that most trust procedures gave at least two suggestions where staff could get independent advice on how to raise a concern or use the policy. Primary care staff respondents were also most likely to get advice from a work colleague (61.7%) but a professional body was the next most frequently mentioned source (37.7%). In this survey, trade unions were most likely to be the source of advice where the respondents were unaware that a procedure existed.

The Importance Of Procedures And Trade Union Involvement In The Whistleblowing Process.

Prior to the research conducted for the Francis Review, it had been argued that internal whistleblowing arrangements were desirable in principle i.e. that allegations of wrongdoing are likely to be dealt with more speedily without external pressure; that those raising a concern in accordance with a procedure were less likely to be victimised for disloyalty; and that such arrangements "contribute to form of organisational justice" by providing opportunities for workers to use their voice (Skivenes and Trygstad, 2015: 18). In the light of the evidence acquired for Francis, it can now be said that there is empirical data which

confirm that having a procedure and following it leads to better outcomes for both employers and whistleblowers.[8] Thus the presence of a procedure is associated with it being more likely that concerns will be raised and that this would be with line managers or other designated persons. If the matter was unresolved, following the employer's procedure made it more likely that a concern would be taken further internally and that the whistleblower would be satisfied with the response. Finally, adhering to a procedure was associated with the taking of advice, investigations being conducted and whistleblowers being praised for the action they took.

Conclusions

Whistleblowing policies and procedures provide the norm for whistleblowing behaviour in an organisation. Those who want to raise a concern will look for guidance and instructions in the whistleblowing policy/procedure, as will those who receive or investigate concerns, or oversee due process within the organisation. Hence we can expect that if policies and procedures are to drive behaviour and interactions within an organisation, it is important that they contain the elements and processes considered to be best practice.

In the light of qualitative evidence acquired for Francis, there remain questions as to how the quality of policies/ procedures relates to the culture of raising a concern or speaking up. Indeed, management interviewees acknowledged that the procedural landscape is often a maze that is easy to get lost in. In so far as it provides evidence that those who follow their employer's procedure when raising a concern have better outcomes than others, the quantitative research for Francis is consistent with the findings of Skivenes and Trygstad (2015) to the effect that institutional arrangements really matter: "whistleblowing procedures in fact render such reporting less risky and increase the opportunities for success."

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[8] We do not pursue the argument here that internal arrangements might lead to a cover–up which does not promote the public interest.

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