Chapter Eleven: Concluding Observations

Introduction

Throughout the period spent writing this book (March – November 2011), the subject seemed timely and increasingly topical and important. This chapter offers an update on very recent developments, which came too late for inclusion in the printed book. Periodically further updates will be posted online ahead of a second edition of the book.

Whistle Blowing

The professional and public media continues to be alive with reports about the care of people in hospitals and care homes. Some whistle blowers have been exonerated and reinstated; others continue to be victimised by employers. Some whistle blowers, reflecting on their experience, conclude that the NHS remains largely unsupportive of whistle blowing and that a cultural change is required (Bolsin et al., 2011). They are critical of professional and regulatory bodies, within and beyond the medical profession, for what they see as double standards – exhorting practitioners to blow the whistle but viewing them with suspicion when they do. They propose the need for clear and unequivocal guidance for doctors and other health care staff, urge the importance of moral leadership by regulatory and professional organisations, and by government, and a review of whistle blowing.

In England, government has indicated that the NHS Constitution will be strengthened to reinforce the existing legal right for health and social care practitioners, and students, to raise concerns about safety, malpractice and care standards without detriment (Santry, 2011). Expectations will be reinforced that staff will raise concerns at the first available opportunity and that NHS organisations will support those health care practitioners and managers who whistle blow by commissioning thorough and independent investigations of their concerns. Government has also reminded NHS organisations that whistle blowing is an essential component of ensuring patient safety, that concerns should be taken seriously and addressed promptly, and that there is no place for confidentiality clauses to prevent disclosure to regulatory bodies (Nicholson, 2012). This reminder refers back to a key NHS Executive Circular (1999) which requires NHS organisations to protect staff who whistle blow against victimisation, and concludes that all staff have the right and duty to raise concerns, and the right to expect that their employers will support them.

A rush of new advice has appeared from regulators. Draft standards for members of NHS boards and governing bodies in England have been drafted following calls during hearings of the public inquiry into Mid Staffordshire Foundation Trust for NHS managers to be held more strongly to account (CHRE, 2012). They propose that NHS leaders must blow the whistle on colleagues if necessary, but it is unclear how such standards are to be enforced.

The embattled CQC has published revised whistle blowing guidance (2011a; b), which advises individuals and service providers of how the Commission will respond when concerns are notified to it. The GMC has issued its own whistle blowing guidance (2012a), which advises that contracts or agreements that seek to stop doctors

raising concerns about poor quality care are totally unacceptable. It reminds doctors who sign such contracts that they are breaking their professional obligations and are putting patients, and their careers, at risk. In further new guidance the GMC (2012b) reminds doctors that they are responsible for the safety and wellbeing of patients when performing non-clinical duties – including when they are working as a manager. The troubled NMC has stated that it intends to establish a "critical standards intervention system" to enable it to be more proactive and also to mirror the GMC guidance to nurse managers (House of Commons, 2011).

This flurry of guidance and exhortation seems oblivious to the fact that the implementation of the Public Interest Disclosure Act 1998 has, arguably, been undermined by changes in employment law reducing employment protection for unfair dismissal and further eroded by a generally cautious and sometimes exceedingly narrow interpretation of the purpose of the Act by Courts with feeble sanctions for employers who victimised whistleblowers. In *NHS Manchester v Fecitt & Others [2011] EWCA Civ 1190*, the Court of Appeal decided that employers could not be held to be vicariously liable for acts of victimisation of its whistle blowing employees by those with whom they work.

Whether these proposals for greater accountability and transparency in health and social care will ultimately provide sufficient encouragement for staff to raise concerns, and sufficient employment protection when they do so, remains questionable on the basis of current experience and attitudes. Whilst such proposals as a duty of candour in the NHS and a strengthened role for whistle blowing in the NHS Constitution are welcome, without a significant cultural change away from a hidden curriculum, they may ultimately prove of little consequence.

It is possible that when the comprehensive Inquiry into the scandal at Mid Staffordshire Hospital is published, it may oblige Ministers to strengthen the Public Interest Disclosure Act 1998 and may better embed whistle blowing in NHS contracts and culture. The Inquiry Report and the responses to it may make it a little easier for staff in health and social care to raise concerns and a little less likely they will suffer for doing so. It may be that more organisations will understand that the raising of concerns is a vital way of improving services and that suppressing them can be dangerous in the extreme. The need will remain for the actions that this book advocates professionals must take.

Meanwhile, the whistle blowing charity Public Concern at Work has reported more inquiries than ever from health and social care. A new organisation, Patients First (http://www.patientsfirst.org.uk), has been formed out of the experience of high profile whistle blowers, such as Dr Kim Hold and Sharmila Chowdhury, to campaign for better protection for NHS whistleblowers and for patients.

Care Standards

Some care home and hospital staff have been suspended for medical errors, falsifying records, poor and abusive treatment, and a lack of compassion and dignity. Some have pleaded guilty to the mistreatment of patients in their care. Improvement notices have been served on hospitals by the Care Quality Commission following dignity and

nutrition inspections, which uncovered non-compliance with essential standards. Some fitness to practise investigations have begun as a consequence.

The Patients Association (2011) has published its third report of patient and carer experiences of poor care in hospitals. It makes distressing reading. It is further evidence of systemic problems in parts of the NHS. The report is critical of how NHS Trusts handle complaints from patients and carers and repeats its proposal that independent clinical patient safeguarding champions should be appointed to scrutinise and challenge levels of care and dignity, and to monitor the long term cultural change that is required on many wards.

In the pursuit of quality and accountability, regulatory bodies have not emerged unscathed. The Patients Association report is also critical of the inspection methodology used by the Care Quality Commission, arguing that a deeper "dive" into hospital wards would uncover further incidents of poor care and lack of compassion. The leadership provided by the CQC has also been criticised by witnesses to the public inquiry into the Mid Staffordshire hospital (Ramesh et al., 2011). The same inquiry has heard suggestions that the Royal College of Nursing may have been out of touch with its members and insufficiently challenging of cultures where incident reporting is poor. Similarly, unions have been criticised for prioritising members' interests ahead of patient safety and high quality care. Finally, the National Audit Office (2011) has criticised the Care Quality Commission for prioritising registration ahead of reviewing compliance with standards through inspection, for failing to ensure that all inspectors have the expertise to assess risk effectively, and for managing its performance without clear criteria by which to judge success.

Whether health and social care practitioners have the confidence to raise concerns is one question. Another is whether regulatory bodies, such as the Care Quality Commission, the Nursing and Midwifery Council, the General Social Care Council and the Health Professions Council have sufficient powers – and indeed capacity and competence – to hold senior managers and governing bodies to account for staffing levels, poor working practices, workload levels, stress on the frontline, and the use of resources. Some of the inquiries that have been profiled in the book cast doubt here.

Equally questionable is the degree to which regulatory bodies and senior managers are in touch with the lived experience and realities of frontline practice, and the dilemmas faced when competing demands, all of which command priority, arrive simultaneously – in health care, for example, the patient with immediate needs, a relative with a question, and multiple clinical tasks to complete. Concerns remain about workloads and whether tasks are being safely delegated. One report, which raises questions about the government's decision to support voluntary rather than obligatory registration for all health care practitioners, suggests that health care assistants are taking on roles and tasks for which they have not been trained, including administration of drugs, compiling care plans and caring for complex wounds (Guardian, 2012). Similarly in social care, there are concerns that social work assistants and social care staff are undertaking tasks beyond their skills and knowledge, partly because of rising demand and falling budgets, with employers failing to assess the likely complexity of work prior to its allocation (Carson, 2011). This is placing both service users and staff at risk.

To take one further example, research into older people's experiences of home care (Sykes and Groom, 2011) has found risks to human rights not just from abuse and neglect but from systemic weaknesses – a lack of understanding of human rights issues, gaps in protection, and inadequacies in service delivery – exacerbated by resource constraints. This research reinforces a theme that we have stressed throughout this book. Many care workers practise with skill and professionalism. However, there is substantial evidence too of lack of respect and hurried work, of people's vulnerability to abuse and indifference, of social isolation and lack of continuity, of a failure to inform service users and carers of their legal entitlements, and of a failure to work in partnership with service users.

Legal Literacy

The evidence underpinning the above questions and analysis has been presented throughout the book. Four final case studies are presented here to highlight the importance of professional accountability and to question whether current health and social care has fully recognised the serious situation that currently pertains within these public services. Three are drawn from inquiries by the Local Government Ombudsman, published in 2011. A finding against Bristol City Council (09/005/944) refers to maladministration due to a failure to monitor the quality of care provided by an independent care home. No formal mental capacity assessment had been done and risks to individuals had not been addressed alongside attention to improving the overall care system.

In a case involving self-neglect, the Ombudsman judged that there had again been a failure to assess the person's mental capacity and to address risk, this time in care planning. There had also been a failure to review (09/013/172). Finally, in a case involving Cardiff City Council (200900981), the local authority was criticised for taking a blinkered approach and for demonstrating a lack of concern and urgency concerning a homeless woman with severe mental distress.

Not all judicial reviews have found against local authorities when they have been scrutinised for the balance struck between needs and resources. However, some councils continue to struggle to act in line with equality law, and with administrative law principles on consultation, when seeking to cut services *(R (JM) v Isle of Wight [2011] EWHC 2911 (Admin)*.

In addition to concerns about care standards, one might question again the degree to which legal and ethical literacy is embedded in health and social care agencies. One might question also the degree to which knowledge about, and skills in navigating dilemmas between doing right things, doing things right, and rights thinking (Braye and Preston-Shoot, 2009) are distorted by the pressures arising from externally imposed targets and budget reductions. The cultures and traditions of some organisations may also draw practitioners and managers away from what they learned on qualifying courses.

Regulation

There are also impending changes in the organisational architecture for health and social work, at least in England. The General Social Care Council will be wound up,

with its registration functions transferred to a renamed Health and Social Care Professions Council. A review of the Health Professions Council consultation on standards of proficiency for future social workers might lead to the conclusion that requirements to hold employers accountable for the working environment they provide are being watered down.

In the current economic and social environment, it can often be difficult for social workers to uphold their duty of care and always act in the best interests of service users, using the principles of good social work. The proposed replacement of the current General Social Care Council Code of Practice (2002) by the draft Health Professions Council Standards of Proficiency and the HPC Standards of conduct, performance and ethics suggests that upholding the social worker's duty of care and ensuring that registrants act in the best interests of service users is likely to be made *significantly* more difficult.

There are four reasons for concern. Firstly, the proposals do not robustly set out the requirement to act as an advocate for service users and to adequately explain what that means. Secondly, a formulation on equality and human rights that falls well short of the reasonable expectations of anti discriminatory practice. Thirdly, an absence of any specific guidance in the Standards of Proficiency on drawing concerns to the attention of appropriate persons, compounded by the vagueness of some of the relevant references in the Health Professions Council's parallel standards of conduct, performance and ethics document. Finally, a fourth concern that the Standards use the phrase 'must be able to' throughout, which has potentially quite a different meaning to the imperative 'must' which is the norm within other professional codes.

There are also concerns (see Community Care online, 10 November 2011) that referrals of care workers for investigation by regulatory bodies are too low given the number of cases that appear to involve staff as alleged perpetrators. This is despite a legal duty to refer staff when they have, or may have harmed service users or placed them at risk, and when they have accordingly been dismissed or have resigned. Equally, there are concerns that, in the organisational context outlined in the book, improvement measures should be stated much more clearly. The Social Work Reform Board (2010) proposed organisational health checks, which arguably should be mandatory rather than advisory, and which could beneficially be extended to health care organisations and cover such areas as safer recruitment, hydration, nutrition, tissue viability, discharge practice, and the openness of the system to feedback and challenge.

Social work students in England have been enrolled on the General Social Care Council register. The likely transfer of the GSCC's fitness for practice function to the Health Professions Council has thrown into doubt whether this will continue pending a consultation which was underway as we went to print, a step many would regret and fail to understand. This proposal sits in the context where, in Wales, the number of students referred to the Care Council for Wales has fallen, arguably demonstrating the positive impact of registration (see Community Care online, 3 November 2011).

One final change to the regulatory framework has been the establishment of the College of Social Work as a professional voice for social workers.   Its birth was marked by sharp disagreements over its funding and future links, and it remains to be

seen how long it will take the College to gain the authority that other professional Colleges have, and what impact ultimately it may have on care standards and outcomes.

The Mid Staffordshire Foundation Hospitals Inquiry is likely to make numerous recommendations, several of which are of direct importance to readers of the book. It was being urged, for example, to give a firm steer on workloads and staffing levels and to recommend the regulation of healthcare assistants. Powerful evidence from the NMC supported the regulation of such staff who deliver a large proportion of front line care in health in order to protect patients (Calkin, 2011).

The government remains staunchly opposed to such regulation and has instead commissioned a voluntary code of conduct and minimum training standards for healthcare assistants in England to bring 'clarity' to the role. It is unclear how such a voluntary code would improve the safety or effectiveness of delegated roles. In social care, despite promises by the previous government to regulate social care assistants, there is no progress in England, though in Scotland all new-start health care support workers employed by the NHS in Scotland are required to achieve a set of induction standards and comply with a code of conduct, with similar developments in Wales.

Health and Social Care Reforms

Subject to the passage through Parliament of the Health and Social Care Bill, Primary Care Trusts and Strategic Health Authorities will be replaced by Local Commissioning Consortia and, in relation to the future education of the health care workforce, Local Education and Training Boards. Local Commissioning Consortia, comprising GPs and other health care professions, will commission NHS services, based on a joint strategic needs assessment, for which they will be responsible, and probably be coterminous with local authority boundaries. Health and Well-Being Boards will be created and hosted by local authorities, by which consortia will be monitored and scrutinised.

Local Education and Training Boards (LETBs) will be provider (NHS Trust) led, sensitive to the needs of NHS services and employers, albeit with strong academic links and responsive to universities. A new body, Higher Education England (HEE), accountable to the Department of Health, will make funds available to the LETBs, monitor their functioning, and approve their governance arrangements. HEE will engage in high level workforce planning, informed by data from the Centre for Workforce Intelligence (CFWI), which will inform its funding decisions and the transfer of resources to individual LETBs. HEE will be responsible for ensuring that LETBs, and the education programmes they commission, meet the standards required by health care regulatory bodies. It will be expected to promote research and innovation in professional development, support the NHS Constitution, promote patients' health and well-being and address health inequalities, and respond to changing service demands.

The reforms have specified priorities relating to outcome measurement, effectiveness, quality improvement, patient safety and affordability. Key NHS service domains are public health, social care (for which a White Paper is expected in April 2012) and clinical practice to prevent premature death, enhance quality of life for people with

long-term conditions, promote recovery from ill-health, deliver positive patient care experiences, and ensure patient safety. These domains will influence the contracts that are put out to tender. A national educational outcome framework will focus on key domains, including:

- ensuring excellent quality care in learning environments;
- employing competent and capable staff;
- ensuring staff and students are fit for purpose and leadership, for instance in working with others, managing services and improving standards of provision;
- guaranteeing excellence of educational learning and development, including continuing professional development, enabling staff flexibility and patient focused responsive services;
- aligning individuals and groups to workforce demand.

It is envisaged that quality education and training will be delivered through various mechanisms, none of which are unfamiliar – learning and development agreements, a quality framework for education commissioning, contract performance indicators, and audit and inspection by the QAA and professional regulators such as the NMC.

Based on the evidence explored in the book, especially the opening three chapters, it is questionable whether these reforms have learned the lessons uncovered by inquiries and research studies, especially relating to commissioning, organisational culture and governance. It is hard to see how reforms to the organisational architecture, which partly entrust the commissioning of services and of education and training to NHS Trusts, about which concerns have been expressed relating to care standards, will improve the prospects for patients and service users. No evidence has yet been been provided that replacing the current NHS architecture with a more "market" focussed NHS, entrusting key decisions to clinical commissioning groups led by GPs, will in any way improve on current arrangements and address the systemic weaknesses to which inquiries and reports, referenced in this book, have drawn attention.

The Health and Social Care Bill has met with the widespread opposition including many Royal Colleges and academic observers as well as NHS trade unions. If the proposals, albeit amended, do become law, then they will constitute a further serious challenge to professional accountability as radical restructuring is accompanied by severe budget cuts and a growing involvement of the private sector. The changes will make the imperatives we have drawn attention to in the book even more important.

The government's much delayed adult care White Paper will have significant implications for social workers in adult services, with changes expected to its legal framework, funding and delivery. Ministers claim they want social workers to move away from care management and gate keeping resources, to community development roles, in which they would map networks of support in communities and connect older and disabled people to these. At a time of unprecedented cuts in local government services, the real impact will be carefully scrutinised and is much more uncertain (Samuel, 2012).

The reality of care for many older people was highlighted by a major inquiry into the home care system. This reveals disturbing evidence that the poor treatment of many older people is breaching their human rights and too many are struggling to voice

their concerns about their care or be listened to about what kind of support they want. The report says hundreds of thousands of older people lack protection under the Human Rights Act 1998 and calls for this legal loophole to be closed. It questions commissioning practices that focus on a rigid list of tasks, rather than what older people actually want, and that give more weight to cost than to an acceptable quality of care (Sykes and Groom, 2011).

Arguably, what might help would be a standard definition of rights and responsibilities to underpin quality and standards in adult social care, and social services more generally, similar to the NHS Constitution in England, which has statutory force. This could cover mechanisms by which people can raise concerns safely and have them acted upon appropriately. It could embrace the responsibilities of employers to equip staff with the right knowledge, skills and organisational environment to drive improvements to quality and outcomes. It could outline a greater role for service users in codifying the standards and outcomes they expect.

Professional Accountability

In such challenging contexts, one objective in writing the book has been to empower members of the health and social professions by outlining individual practitioner rights as well as responsibilities, and detailing the duties placed on organisations. Where possible we have emphasised the possibilities for highlighting, and the need to raise issues collectively as accountable professionals, both as a means of demonstrating shared concerns but also because a collective voice is often more powerful and less susceptible to victimisation than individual voices. We have underlined, however, that whether or not work colleagues raise concerns, if such concerns do exist, each individual practitioner has a duty to draw attention to them. Allied to this focus has been the objective of shifting mindsets, from seeing organisations as a form of domination, where individual practitioners and managers feel powerless, even victims, to organisations as locations where leadership at all levels, participation, influence, advocacy, learning and change are all possible. Chapter four and all the subsequent chapters in the book have been designed to assist with this change of perspective. The components of good practice and good management are set out there.

Professional accountability is a daunting challenge but also an opportunity. It is daunting because of the organisational context in which many practitioners and managers work, and because of the standards placed on staff by their professional codes. It represents an opportunity because these same standards, and the maintenance of healthy organisations, can make a significant contribution to people's health and well-being.

Professional accountability in the health and social care professions depends in no small measure on the quality of relationships between staff and service users, practitioners and managers, and teams of people in organisations. It rests on how well those involved manage and respond to certain uncertainty, the challenges and dilemmas that the work generates, the anxieties that practice and the management of practice create, the diversity that people bring and the disadvantages that impact on them. Hopefully, this book, with its emphases on legal and ethical literacy, emotional

resilience, and a duty of care to staff and to service uses, will provide one resource with which those in the health and social professions can hold true to the purposes for which they were created.

Into the future

Even more than we had realised when starting to write this book, the need for health and social care professionals to stand up for those they work with and for, has never been so important. Professional accountability and the duty of care are not optional extras. Policy changes are making our proposed courses of action more relevant and necessary than ever.

References

Bolsin, S., Pal, R., Wilmshurst, P. and Pena, M. (2011) Whistleblowing and patient safety: the patient's or the profession's interests at stake? *Journal of the Royal Society of Medicine*, 104, 278-282.

Braye, S. and Preston-Shoot, M. (2009) *Practising Social Work Law*. 3rd edition. Basingstoke: Palgrave Macmillan.

Calkin, S. (2011) Ward ratio of 60:40 is low as you can go, CNO tells Mid Staffs inquiry. *Nursing Times,* 8 September.

Care Quality Commission (2011a) *Guidance for People who Work for Providers that are Registered with the CQC*. London: CQC.

Care Quality Commission (2011b) *Guidance for Providers who are Registered with the CQC*. London: CQC.

Carson, G. (2011) Making room for paraprofessionals. *Community Care*, 3 November, 28–9.

Council for Healthcare Regulatory Excellence (2012) *Draft Standards for Members of NHS Boards andGgoverning Bodies in England.* London: CHRE.

General Medical Council (2012a) *Raising and Acting on Concerns about Patient Safety.* London: GMC.

General Medical Council (2012b) *Leadership and Management for all Doctors.* London: GMC.

Guardian (2012) Healthcare assistants working out of their depth, NHS survey warns. *The Guardian*, 11 January.

House of Commons (2011) (*Para 16 Evidence p 19 Annual Accountability Hearing with the Nursing and Midwifery Council Seventh Report of Session 2010–12.* Report, together with formal minutes, oral and written evidence Ordered by the House of Commons to be printed 19 July 2011).

National Audit Office (2011) *Report by the Comptroller and Auditor General. The Care Quality Commission: Regulating the Quality and Safety of Health and Adult Social Care*. HC1665. Session 2010–2012. London: NAO.

NHS Executive (1999) *HSC 1999/198 The Public Interest Disclosure Act 1998 Whistleblowing in the NHS*. London: Department of Health.

Nicholson, D. (2012) *Compromise Agreements in the Public Interest Disclosure Act 1998*. London: Department of Health.

Patients Association (2011) *We've Been Listening, Have You Been Learning?* London: The Patients Association.

Samuel, M. (2012) Burstow: social work to be at heart of care White Paper. *Community Care*, 1 February.

Santry, C. (2011) Protection for whistleblowers to become a contractual right. *Health Service Journal*, 18 October.

Social Work Reform Board (2010) *Building a Safe and Confident Future: One Year On*. London: Department for Education.

Sykes, W. and Groom, C (2011) *Older People's Experiences of Home Care in England*. Manchester: Equality and Human Rights Commission.