The People's Inquiry: One Year On

Evidence presented by Roger Kline (RK), researcher and author.

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Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louise Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

RL:
The purpose of us being here today is to re-visit the report that we wrote a year ago to see whether or not we've made much in the way of progress and to gather evidence from key opinion formers and leaders in the NHS to see where we are and to re-visit our report. We are particularly interested of course in your special topics of whistleblowing and racial discrimination. We had some powerful evidence I think last time on those topics and we value your views on where we are today and whether or not we've made much progress in the last few months.

RK:
What I thought would be helpful would be to talk about workplace culture and the link between the treatment of staff and the care of patients. Because I think it's a link, and there is a lot of research and common sense that says there's a link. But it's not at all clear in the way that the health service is run and managed that that link is understood by almost any of the parties that ought to understand it. So I'm going to talk a little bit about culture, by which I mean 'how we do things around here', talk a little bit about two examples of culture – the treatment of BME staff and the treatment of those who seek to raise concerns – and then at the end talk a little bit about bullying. All the way through I'm going to try to make the link between how you treat staff impacts directly on the care of patients.

If you look at the first page, if you look at the bottom there is a picture of a horse (Figure 1). This features a 77-year-old lady called Sheila Marsh, who was a patient at Wigan. It's a wonderful picture because it sums up what's great about the health service. This is a lady who was dying. She was an agricultural labourer and she was asked 'have you got anything else you would like us to do?' and she told the bereavement nurse, 'I would like to see Bronwen'. Who is Bronwen? Bronwen was a horse that she foaled 25 years previously.

So this is a hospital that is driven by values, it's got a really healthy culture both in terms of staff and patients. They said OK let's see if we can do it, can we get the patient to the race-course? No we can't, she's too ill. Could we get the horse to the hospital car park? Yes, we could. If we did, would the patient be safe to take outside for a few minutes? Just about. So that's what they arranged. The picture you see is of Sheila, aged 77, in the car park and she just said 'Bronwen?' and the horse trotted over and came down and nuzzled her.

[Figure 1]

I am just using this as an example, because this is a trust whose staff engagement scores are through the roof, whose treatment of BME staff is amongst the best in the country. It's the only trust I am aware of where the rates of bullying are so low and the rates of bullying of BME staff are HALF those of white staff – the opposite of where it is in most places. This says to me two things. It's possible, but it also means you have to understand how these things are done.

If you look at the next page, that's a quote from the Francis Report. The two women there, some of you will know who they are. Eleanor Donnelly who was driven out of Mid Staffordshire Hospital after raising concerns, and Julie Bailey, who I shared a platform with last week, and who told me she is still living in a caravan in Worcester having been driven out the entire town of Stafford. What Francis says there is that you want a common culture of caring rather than a culture of fear.

In terms of London the two quotes below from Robert Francis and Ian Kennedy I think are particularly pertinent because London even more than some other parts of the country sums up the perfect storm the NHS is in – rising demand, and in real terms static or falling resources. So the issues that Robert Francis talks about, the overwhelmingly prevalent factors being shortage of resources, the right sort of staff, failure of leadership are directly relevant.

For example I went into Barts two weeks ago. If you want an example of how not to run a hospital I'd say that was a pretty good example. There are some good hospitals in London which I can talk about a bit later. But it seems to me those issues are very much alive and well and the culture in some of these hospitals continues to be poor. Ian Kennedy around the Bristol Royal Inquiry a few years ago said 'bullying is a key issue'. He said it at the time and he has said it since. I think these things come together.

The advantage that we have and that the policy makers ought to be relying on is that what common sense and intuition tells us – if you care well for staff they are more likely to care better for patients. This is now underpinned by some pretty solid research from Mary Dixon-Woods, Jeremy Dawson and in particular Michael West (with a quote from Michael West from a couple of years ago). They show the inverse correlation between harassment, bullying and abuse from staff or managers and the care and compassion that staff are able to provide. It's pretty obvious. So there is a lot of research that underpins common sense.

I want to touch briefly on two examples that illustrate the point I want to make. London has 41% of its directly employed NHS staff from black and minority ethnic backgrounds. It would be higher if contractors were included. 45 per cent of patients according to the last census (it's probably slightly higher) are from black and minority ethnic backgrounds.

But I got a tweet from a nursery owner in Greenwich about January of this year in which she tweeted a picture of the Lewisham and Greenwich Hospitals Trust Board, and said 'do they all look like this?' – it was entirely white. I thought 'I don't know the answer to that', so I went and looked. I FOI'd all trusts in London.

The responses were astonishing. For example, a number of trusts – including Barts – said the Data Protection rights of our board members override the public interest if you want to know the ethnicity of our board members. To which I said, 'but you have colour pictures and names of your board members on your web site, I'm just checking'.

What I found was of the 40 trusts, only one had a BME chair, none had a BME chief executive, and 17 of the 40 had no BME members on the board. I'm talking about places like the Homerton, the Royal Free, Barnet, Enfield and Haringey Mental Health Trust. It is just not the case that such trusts could be in touch with local communities – that's what they look like. Insofar as the data allowed me to draw conclusions, there has been a *decrease* in the proportion of BME board members in recent years. They were not only disproportionately white, they were disproportionally male.

If you look at Figure 2, that's the front page of the *Camden New Journal*. You've got 40 board members from UCLH, the Whittington and the Royal Free. All are white: they do not look like a typical bus queue.

[Figure 2]

On the subject of the Royal Free, my children were born there. The Royal Free said initially that they weren't going to reply because of their data protection rights. Then I said 'but your pictures are here', then they said 'all the members of our board are British'. I said 'is that white, green, blue or yellow British?' and the company secretary said 'Oh they are white British'. Of course they are.

This was in London.

RL:
I really don't want to interrupt your flow because we don't have long to hear you, but I mean the reluctance to do that is, what, embarrassment?

RK:
No I think it's more symptomatic of a kind of avoidance and denial of a difficult issue. I don't think these trusts have even thought about the issue, but once the issue was raised they can see – maybe because it was coming from me too in some cases – this was going to be a bit embarrassing. The idea that I wouldn't find out was pretty silly.

The same is true nationally in trusts as for London. We have now looked at the really snowy white peaks of Monitor, NHS England, CQC, Trust Development Authority, Leadership Academy, Health Education: not a single BME director. Just a couple of non-exec directors of NHS England. Monitor, which is based just off Waterloo is astonishing. It's in the report. It's an astonishing profile of its workforce. It is snowy, snowy white – an entirely white mountain. Even in CCGs where you might have thought there would be rising numbers of BME GPs, no. The only data that's available that HSE won't publish shows that out of 53 responses to a survey, 51 were white.

So we have a problem. The reason it's a problem – incidentally the proportion of nursing managers who are BME is actually LESS now than it was in 2003, despite the statutory increase in the number of BME nurses – is there is a pattern of exclusion. That's paralleled by or caused by the treatment of staff. It's like expecting staff to get to the second floor and there's no escalator, lift or stairs.

For example in 2013 I looked at a sample of 60 trusts and I discovered that it was one and three-quarters times more likely that even after BME and white people had both been short-listed that the white person would be appointed. One and three-quarters times more likely. Not a single report that I looked at mentioned this figure. It's twice as likely that BME staff will enter the disciplinary process, and by every other indicator BME staff are less favourably treated. There is no indicator where white staff are less favourably treated.

If you triangulate that with the outcomes of the National Staff Survey it confirms that what we think is happening probably is happening. It's a quarter more likely that BME staff will say they are bullied. It is two and a half times more likely that BME staff will say that they don't believe they are fairly treated in career progression and promotion, and ditto discrimination. The data I have got there is consistent going back 5 years so it's solid.

Just as an aside, the proportion of BME staff saying they are bullied by relatives and the public is the same as it is for white people. In other words, it's not that BME people complain more, because they are quite specific about what they are complaining about.

Why does all that matter? It all matters because how staff are treated affects the care that is provided and received, not just in terms of patient experience but in terms of outcomes too (Figure 3). I'll come back to that if there is time.

[Figure 3]

There are six reasons. I want to focus on one (Figure 4).

[Figure 4 – middle slide]

If ethnicity is an issue that prevents you appointing the best people (because it's more likely that all things being equal white people will be appointed), that means patients are not getting the best staff that they might get. There's a huge impact in terms of morale, absenteeism, turnover, people retiring before they need to, discretionary effort that arises from people not being treated fairly, discrimination makes staff ill – there's a wealth of information on this particular point from the US, but also from here.

There's a load of research evidence about the benefits for patients for having diverse teams. The work was originally done about the benefits of women, not just all-male teams, but it now applies to ethnicity and age. Mixed teams are more able to work better together. Finally of course if you do have boards that are entirely unrepresentative of the populations to whom they are providing services that will inevitably have consequences both for how services are commissioned and how they are provided.

The issue I just want to spend a moment on is the culture issue. It's the relationship between the treatment of staff and the care that's provided. Figure 5 is a quote from Jeremy Dawson, 2009.

[Figure 5]

What they did was they took basically all the staff survey data, all the patient survey data and looked for linkages. They concluded the staff survey item that most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background. They did similar work 3 years later and the results were the same.

Experience of BME staff was a good barometer of the climate of respect within the NHS. If BME staff were engaged, motivated, valued and part of the team with a sense of belonging, patients were more likely to be satisfied with the service they received. There's other work from West looking at clinical outcomes not just patient experience.

That provides a new narrative around the treatment of BME staff where it's not just it's morally wrong that people are treated badly, but it's *bad for patients*, and that's what underpins the new initiative that Simon Stevens is supporting in the NHS around a work-force based equality standard which I have been lucky enough to help draft.

I want to briefly touch on patient safety and whistle-blowing. Robert Francis called patient complaints 'gold-dust'. If I remember rightly, Roy, you had a phrase where you didn't understand why managers weren't crawling around on knees begging staff to raise concerns so they knew what

was going on. The Bristol Inquiry was very clear in 2001 on the importance of an open, learning culture, where staff feel able to raise concerns. It's self-evident, it's common sense. But it isn't happening on the scale that some would want us to believe.

Have a look at the Health Select Committee evidence from the NHS Confederation and the NHS Employers on the 8 July [2014] where there was a fairly serious attempt to persuade (I think unsuccessfully) the committee that things were 'in a much better place than we used to be'. Because the evidence doesn't support that that's what has happened over the last 4 years, that's the period I have looked at the data for.

In the last Staff Survey, 28% of staff were unable to say they could answer 'yes' to 'do you feel safe to raise your concerns?'; 44% never got a response when they did raise concerns and most interestingly – which nobody seems to have paid any attention to – the number of concerns being witnessed is stable for the last 4 years. The number of concerns being reported has fallen significantly.

Nursing Times did a survey one year after Francis earlier this year, 37% of staff said they thought culture was a bit better than it was a year before; 13% said it was worse – and 50% said it hadn't changed. But if you ask the people who had raised concerns, 47% of nurses who had raised concerns said they had suffered personally negative consequences as a result of doing so. That seems to be a pretty catastrophic piece of data that nobody seems to spend much time discussing.

The King's Fund survey of culture and leadership earlier this year said the most important conclusion was that kind of almost cultural dissonance between what staff thought and what boards thought. I just pulled out a couple of examples: 84% of board members think their organisations are characterised by openness and a policy of being challenged but only 31% of nurses did. Ditto on whether they thought concerns would be dealt with appropriately.

That applies to race discrimination too. I will just digress slightly. I spoke with a chief executive of a trust a few months ago, not in London. I was with a BME whistle-blower. I said to him, it was quite a difficult meeting to start with, 'I don't think you have any idea what your BME staff think about what goes on in this place?' He said 'what should I do about it?'. I said lock yourself in a room with a group of staff and just ask them – Chatham House rules.

He did, to his credit. He said it was the most distressing meeting he has ever been to in his life. The majority of the group there were crying at one point or another during the meeting as they described their experiences. To his credit he has set about like a kind of whirling dervish, changing the culture of that organisation, which was in a very bad place.

Boards simply don't accept that there are systemic problems in the majority of trusts. What's really interesting about the data is you have consistently over several of the questions of the Staff Surveys over the last 4 years, that the majority of people think nothing's changed, a minority think things have improved and another minority think things have got worse. So what's going on there?

Those answers match the answers that Michael West has come up with when he looked at staff engagement. In other words, the gap between the better trusts and the rest is growing. That's quite important I think, because it helps to understand anecdotally some trusts clearly are getting much better, others don't seem to be changing and some are distinctly getting worse.

I've got some pictures there (Figures 6-8). I think you've met Kim Holt, my colleague who is a sort of fellow unpaid director of Patients First. I think you've met Charlotte from Barts and I've just put some other people there, including at the bottom there Dr Kevin Beatt, who won his whistle-blowing

tribunal last week. The trust are so upset they are going to spend more taxpayers' money. And of course there is one member of your panel who is both BME and a victimised whistle-blower sitting at the end there [Naledi Kline].

[Figures 6-8]

Finally, bullying seems to me to be the glue that holds all this together. Twenty two per cent of staff are bullied, 23% last year, it's an incredibly high level of bullying for a caring organisation. Less than half the cases are reported, the proportion of cases of bullying being reported is falling significantly.

Bullied staff are less willing to raise concerns. They are going to be less willing to admit mistakes. They are going to work less effectively in teams. They are going to show less discretionary effort and they are going to show less compassion to patients, because if you are being bullied it's pretty hard to treat with the appropriate care those you look after.

What's astonishing in the health service about all these cultural issues, which clearly impact on patient care, is that we don't do with them what we do with anything else that we do with patient care. What do we do? We look at the data. We try and understand the data by talking to the patients and the staff. Having identified the problem we see if anyone else has had a similar problem and has cracked it or is cracking it and we put in place some kind of learning loop. We don't do that on race discrimination, we don't do it on whistle blowing and raising concerns.

So the question is why? There's this lovely quote from Robert Francis which I'll read out:

> 'There lurks within the system an institutional instinct which under pressure will prefer concealment, formulaic responses, and the avoidance of public criticism.'

I think at a time of rising demand, falling or static resources that's a particularly dangerous approach to take towards work-place culture.

I will finish on a slightly controversial note by just looking at the agencies that ought to be addressing these issues.

Boards – there are exceptions of course – tend to be over-concerned with reputational issues rather than interrogating what's really happening. HR on the whole, there are exceptions, are quite happy if I want to go from A to B, to tell you how to go there without asking whether that's the right place, or the right direction to travel in.

Professional regulators never properly interrogate the data they are presented with. They never ask about their patterns of victimisation and whistle-blowers. They never ask why for some London hospitals the only nurses that are referred are from BME backgrounds.

Trade unions, with some honourable exceptions, are over-concerned it seems to me with what staff get paid rather than what they do. That's the powerful area that trade unions should be involved in and this Commission I take it is a little bit of a part of that.

Professional bodies tend to look the other way. The Department of Health spent the last 15 years telling us every year things are getting better, like that French doctor, Dr Quai, who said 'the way you get better is every day in every way tell yourself you're getting better and eventually you kind of will'.

In London just to compare finally two trusts. I went to Oxleas trust for a BME history background. The chair spent the entire day sitting in the room and so did the HR director, they knew everybody, they were respected. At Barts I went to a similar meeting: no senior staff there – and you know the situation at Barts.

It's an important challenge and I think it's something that to some degree was missed out of your otherwise excellent original report. Because this is something that the government talk about but don't do anything about.

RL:
That was excellent. Thank you so much. Thank you very much for joining us. We are running slightly behind time. I know you have had to reorganise your commitments to be with us. Can we steal 5 minutes from you?

PT:
Bullying and victimisation covers an enormous range: things about race and everything else too. An enormous range of things. Would you describe it as something that is systematic and endemic, that starts with Jeremy Hunt ringing hospitals and bullying them, chief executives feeling bullied, CQCs bullying as recorded by Roy, and just gets passed all the way down the line? But when you look at somewhere good that's got it right, like Oxleas, how did they break that bullying chain of command?

RK:
The first thing they did was to accept they had a problem. It does come all the way down. It's also compounded I think by the hierarchical nature of the training of doctors and nurses which is very deferential. So you've got a lot of things coming together and then the over-excessive focus on targets. In the organisations where it's changed, let me talk about Wigan because I've been to Wigan twice. I was allowed to sit in on their senior management team 2 weeks ago.

What's startling about Wigan is you have leaders who don't try to boss people about, who are clear that blame doesn't work. Who will not tolerate bullying themselves. So the chief exec and the medical director every Thursday morning walk around the parts of the hospital, that's all they do for 3 hours. Unannounced, just talking to people. The week before I was there the first time they walked through one department, I won't say which one. They knew there were issues because of their own staff survey, they are really into data. They just drill down into everything. They knew there were issues here, they had picked it up anecdotally.

They spent 3 hours there. No one said anything to them about it. They walked down the corridor, they knew there were issues, and the medical director says to Andrew Foster, 'There's a group of five people following us Andrew I think we should stop just around the corner'. So they did and they said 'Actually we'd like to talk to you, there's terrible bullying going on in our department'. They listened to them. They checked. They interviewed the head of the department and they knew there had been systematic problems over the previous year. They suspended the head of department, because they had a wealth of evidence but hadn't been able to pin it down.

PT:
What kind of bullying? Give us some examples.

RK:
Oh everything might fit into the ACAS definition with bullying. So it was a mixture of shouting at people and also subtle undermining. You get missed off an e mail list, you don't get invited to meetings. Your work is scrutinised much more than other people. You are embarrassed or

sometimes humiliated in meetings. You get your shifts that you are allowed to work and suddenly it becomes more difficult for you to do the shifts that you wanted to work.

If you're a psychopath there's a multitude of ways in which you can undermine or marginalise people. Some of them are very difficult to respond to because they are not in your face and it's often just picking on one or two people at a time, not everybody at a time or a particular group of people at a time.

What they have done in Wigan, what they did in Ipswich, is basically tried to work with staff, treat staff properly, the motto is treat them as we would like to be treated. Over time it works. Especially if you create a culture in which people can raise concerns. What's great about Wigan is they are very open that they haven't got there yet. I think that's the key. The key is to accept you have a problem, is to look at the data and listen to the staff. So although many trusts would think 'I'd give my right arm for that' they know they are not there yet.

RL:
We are going to have to close, but before I do yes it's interesting because Andrew Foster is an exceptional leader. We had evidence earlier about Healthwatch and all that not making much of an impact. His local Healthwatch people are making huge progress because he's taken it by the neck and said 'we need your input'. One might conclude that this is clearly about leadership isn't it?

RK:
I don't think it's rocket science. Andrew and Dr Umesh Prabhu work brilliantly together. But there are people, there is a cohort of people around the system who are really trying to change things. I can rattle through some of their names. I've mentioned Oxleas because it's in London, but there are maybe 30 or 40 trusts around the country it seems to me that are making serious efforts to change the way their staff are managed, to make patients really the centre of what happens, to move away from a kind of dictatorial macho style of management.

FW:
I want to make two points. First of all I welcome Roger's report which is fantastic. He's stepped back and that is what is difficult when you are in the NHS you lose focus sometimes, you almost expect that things have gotten worse and somebody actually pointing out to you. I looked at my board again and I thought 'Yes, well bloody hell. Absolutely right. I sit mid-way between Peckham and Brixton, and the only BME person on the board is Dr Ghulam Mufti, he's there as one of the medical team. So that was incredibly useful. I could double the number of examples of how you can bully somebody. I could write a book on how to bully people effectively, and then we could write a book on how to deal with that.

When I looked at my board and drilled down, I think it was not that they didn't reflect the community but that they reflected a *different* community: they advertised in *The Sunday Times* for people from business. I think that's why they are overwhelmingly white. The other thing is in my experience now that BME staff are leaving. They are not putting up with bullying, they are leaving and I wonder how much that is part of the problem in terms of staff shortages.

RK:
There isn't time to go through how we've ended up in the situation that we have. I think that's something quite subtle. I think what's important is there is now a national initiative that's going to try and tackle some of this. If the question I was asked was 'is the NHS institutionally racist?' I think the answer will be based on how it responds to the initiative that's now in place, because a

significant number of trusts say yes we're going to do this. I know that there are trusts who really don't want to do it ,or don't even think there is a problem.

JL:
Just a very quick question. Is there, do you think, a correlation between the financial situation and the pressures on the trusts from external financial pressures and the prevalence of bullying?

RK:
I think there are two correlations. What is it that drives bullying? If times are hard, over-work, targets, managers feeling under threat, thinking 'Just do it'. This is the management style, 'just get on with it'. Equally the trusts that have cracked this are finding of course they're getting extra discretionary effort, more productivity, lower absenteeism rates from their staff. So at both ends it's wrong. The correlation is in both directions.

RL:
I think managers have a choice, don't they? They say either 'just get on with it, I've got to do it', or if they get everybody together and say 'look, this is all our problem let's deal with it together'. A bit like Sam Jones does at Watford.

RK:
The meeting I was invited to at Wigan was discussing how were they going to cope with 5% cuts. The chair said 'I want to know the clinical implications of any suggestions that we cut staffing. I'm not interested in knowing you've found the 5%. I want to know the clinical implications.'

RL:
Roger, we could go on for a lot longer but I'm afraid we don't have time. It's been enormously enlightening. Thank you so much.