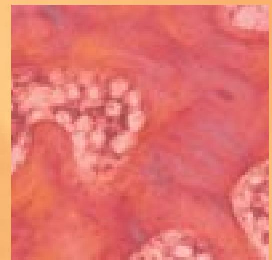
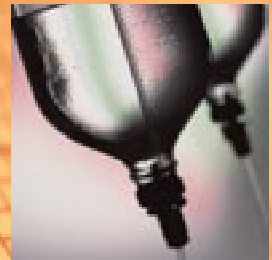
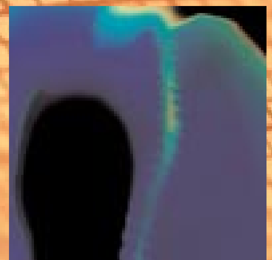
A UNISON HANDBOOK

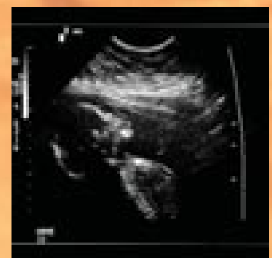
THE DUTY OF CARE

A handbook to assist health care staff carrying out their duty of care to patients, colleagues and themselves









UNISON
the public service union

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Preface

The Duty of Care is intended to assist all those seeking guidance on how best to question and challenge unsafe practice in the NHS. It will also be invaluable to those seeking to influence new plans to improve services and change staff roles.

The Duty of Care builds on previous work by UNISON such as our "Be Safe" campaign to assist nurses, midwives and health visitors to highlight concerns about unsafe practice. The Duty of Care is much wider in scope, however, and seeks to give guidance to staff across all healthcare occupations

It is written as an authoritative guide to legal and professional conduct issues for all health care staff. It places those issues alongside the framework of health and safety statute and case law. It is written in a way that is applicable to all NHS staff and to those in the private sector who have concerns and wish to find an effective and responsible way of voicing them.

It sets out the principles that should underpin the approach of all in the NHS - including the most senior managers - to service delivery, the management of change, the treatment of staff, and the creation of a safe working environment.

This handbook is the workplace manual to complement UNISON's Positively Public campaign in favour of high quality public services. It should help UNISON members to be even more effective as the guardians of safe, effective and accountable health services.

Karen Jennings

National Secretary (Health)
January 2003

1. The purpose of this book

1.1. The central issues.

This handbook is designed to give practical guidance to health service staff at all levels and in situations where there may be a conflict between:

- what their employer expects them to do

and

- what they believe is in the best interests of patients, the health of colleagues or themselves, or the wider public interest.

These situations might include:

- being expected to undertake an excessive or unsafe workload,
- being asked to implement a questionable delegation of tasks or roles,
- being told to follow potentially unsafe instructions,
- being expected to work in an environment unsafe for staff or patients,
- working in a workplace where a climate of fear prevents proper concerns about patient care or staff safety being raised
- being asked to collude in inappropriate allocation or reduction of resources not in the best interests of patients.

The handbook is written for all health service staff - registered professional or non-registered, managers or not, clinical occupation or not - who find themselves in these and similar situations.

There are differences between the circumstances facing a state registered professional and someone who is not, but the key themes are the same. The main difference is that a registered staff member faces the additional issue of what their statutory professional body might expect them to do in the interests of patients. This is explored further below.

Health service "modernisation" is occurring

at a time when there remain substantial gaps in staffing, shortcomings in local leadership of the NHS, and a reluctance to involve staff and their trade unions adequately in policy development and implementation. Yet with the introduction of Clinical Governance, a Code of Conduct for NHS Managers, and a growing public awareness of the rights of patients and the rights of employees, there are an increasing number of situations where clear advice is needed to ensure that safe and effective practice is the priority.

The handbook is intended to assist good practice and improve services by giving guidance on:

- what to do in urgent situations where there may be a conflict between, on the one hand, what the employer immediately expects of the employee, and, on the other, the individual employee's duty of care to patients, colleagues and their employer, and the public interest.
- what to do when there are longer standing concerns such as excessive workload, inappropriate delegation of tasks or roles, or a bullying culture which makes raising concerns difficult.
- how to ensure that proposals for changing services, service delivery or the available resources tackle concerns about unsafe practice effectively and positively, so that the improvement of services and safe practice go hand in hand, rather than being in conflict. We will want to influence those discussions positively and in partnership with management.

1.2. Better treatment of staff means better healthcare

We do not share the view held in some quarters of the media and politics that improving the treatment of staff is somehow at the expense of better treatment of patients. In fact, the opposite is true.

Recent research (1) confirms that excessive workloads, the imposition of inappropriate targets, a failure to value staff, and the inability of staff to do the job they believe needs doing, are crucial factors in driving staff out of the NHS. If staff are really to have some ownership of NHS targets and be part of decision making, then the issues discussed in this handbook have to be integral to those discussions.

Central to our approach is a belief now

endorsed by ministers and by academic evidence, that better treatment of staff will directly benefit patient care.(2) This must include ensuring they are able to highlight and pursue legitimate concerns.

This handbook is written to enable UNISON members and others to be the best possible guardians of high quality, effective and safe services, valuing both patients and staff. After all, the one million health service staff and their families are themselves users of NHS services.

2. What this handbook covers

Chapter 3 summarises some of **the pressures NHS staff are currently under which might influence this conflict** - more flexible working, changing services and occupational boundaries, excessive workloads, inappropriate management culture, cover-ups and secrecy, and tensions with the private sector or self-employed GPs.

Chapter 4 sets out the **legal rights and obligations of employees and employers.**

Chapter 5 explains **the duty of care, the public interest, and the role and status of Codes of Professional Conduct, and Health and Safety law.** It explains what standards staff are expected to work to, what constitutes negligence, and what principles might help resolve potential conflicts between management instructions and the various duties owed to patients, colleagues, oneself and the wider public.

Chapter 6 sets out some **statutory rights** which might conflict with management instructions in respect of safe working or the working environment.

Chapter 7 summarises **clinical governance** as a crucial approach linking the treatment of staff with the treatment of patients.

Chapter 8 summarises **the Human Resources strategy NHS employers are expected to be following** which should have pre-empted many of the problems we identify.

Chapter 9 summarises the **pressures on NHS employers** which may affect how the conflicts this handbook discusses are dealt with.

Chapter 10 sets out the **legal rights of staff where conflicts exist which may be caused by the acts or omissions of employers or staff.** It sets out some principles on how to resolve them. It then sets out in more detail **how**

individuals should tackle these issues and how these problems should be approached collectively.

Chapter 11 suggests some ways to influence "modernisation" locally.

Appendix 1 contains a **checklist** based on some of the issues raised in this handbook to be used when facing the sort of conflicts it describes.

Appendix 2 contains some **pro forma letters.**

Appendix 3 contains extracts from the NHS **Code of Conduct for Managers.**

Appendix 4 contains **references** listed in the handbook.

Appendix 5 gives some links to other useful information.

UNISON members should note that the entire text of this handbook with supporting materials and useful links is on the UNISON web site at http://www.unison.org.uk/healthcare/dutyofcare

Summary

The pace, complexity and scale of the changes in service provision and the NHS workforce are breathtaking. These changes mean it is essential that all NHS staff are involved in discussions about developing new services or changing existing ones. There is no doubt that creating a healthy and safe working environment, in which staff are respected and encouraged to develop their skills and knowledge, improves patient care. To succeed in this, the duty of care which the individual member of staff owes to patients, colleagues, their employer, themselves and the public interest, must underpin both service delivery and development.

3. NHS changes and the duty of care

3.1. The pace and scale of change

Consideration of how to challenge potentially unsafe working practices is especially important because of the radical changes being introduced in working and clinical practices in the NHS. The statement below, drawn up by one of the government taskforces established to help implement the NHS Plan in England, summarises some of them. These ideas are developed further in each country in the Human Resources (HR) plans produced on a regular basis. (3). Examples of the kind of developments likely to become common are readily available (4).

3.2. The pressures on staff

The changes in the NHS, especially those introduced whilst there are still staff shortages, and immense pressures on managers to meet targets and achieve a good

“ The vision of the future for the NHS is one of fast, responsive, high quality services delivered by multi-disciplinary teams in which the contribution of each member is recognised, valued and rewarded.

There will be more staff, working in better conditions, with more time for direct patient care, for service planning and personal development.

There will also be a transformation in the way staff work. Greater flexibility in roles and responsibilities will allow patients to receive high quality care from the most appropriate professional. There will be less delay, greater continuity of care and a more personal, responsive service. The shift to multi-disciplinary team working will be accompanied by

much greater use of integrated pathways and care protocols, developed by staff with the involvement of patients and carers.

- *Doctors will spend a greater proportion of their time on direct patient care, concentrating expertise on patients whom they need to see and spending more time with those patients; GPs will be able to develop specialist skills and take referrals from their colleagues*
- *Nurses, midwives and allied health professionals will have a greater range of responsibilities for decisions about patient care, from diagnosis through development of a treatment plan to discharge*
- *Health care assistants and other support workers will have expanded roles in raising standards of basic patient care, improving communications with patients and carers and providing support for clinical activities within multi-disciplinary teams; and will also be able to develop into new roles*
- *Staff in non direct care areas such as cleaning, portering, catering and administration will be able to develop in their existing roles, with their contribution recognised and valued, and will have the opportunity to move into health care roles with appropriate training."*

NHS Workforce Taskforce Vision January 2001

public profile, will require vigilance from staff at all levels if the duty of care to patients, staff and managers is to be safeguarded.

- it is now accepted that there are **excessive workloads and inadequate staffing** levels in many occupations (5)
- increasing evidence of the scale of **bullying, harassment and violence towards staff** has emerged in recent years (6)
- despite strictures by ministers about openness, local whistleblowing policies, clinical governance and the Public Interest Disclosure Act, there is still a **climate of secrecy and intimidation** in many organisations, making it more difficult to flag up concerns about the duties of care or the public interest.
- the rapid changes in **primary care** have given a greater management role to GPs - many (but not all) of whom have little management experience
- the role of the **private sector** within NHS care has grown without ensuring its standards, values, safety and culture are as good as those of the NHS
- a continuing gap between what **HR policies** are supposed to be and what is actually happening
- the **poor working environment and health and safety practice** highlighted a few years ago and slowly improving (7)
- insufficient attention paid to the hard evidence that **good employment practices** improve patient outcomes

New ways of working underpinned by employment security and safe working practices are a potential win-win for patients, staff and the NHS. We are still a long way off that goal in many organisations.

Summary

This chapter considers the potential for conflicts between management instructions and obligations arising from the duty of care and public interest, the obligations arising from Codes of Professional conduct and the statutory rights and obligations of employees.

4. The contract of employment and the duty of care

Fig.1. Potential conflicts with management instructions

	Statutory rights and duties
Management instructions	Professional Code of Conduct
	Implied duties of care and to the public interest

4.1.The contract of employment

All employees have obligations and rights arising from their contract of employment. These may be found in various documents:

- the statement of terms and conditions of employment every NHS employee must receive within two months of starting work - which must include details of the salary paid, holiday entitlement, and so on (8)
- other documents referred to within the statement of terms and conditions or which are otherwise drawn to the attention of the employee - such as disciplinary procedure, job descriptions, clinical protocols and standards, works rules (on everything from parking to expenses to health and safety)
- statutory terms which are assumed to apply to all contracts (eg health and safety legislation, equal pay rights, anti-

discrimination legislation, unfair dismissal and redundancy rights, the right to whistleblow.)

2.2. "Implied" terms of the contract

In addition to the above rights, all contracts of employment include **"implied duties".** These exist whether or not they are actually written down as part of the contract. They are crucial to an understanding of how, when and why unsafe instructions or circumstances can be challenged.

They include a duty to **their employer** to:

- work in accordance with lawful orders
- co-operate with their employer
- serve the employer faithfully and honestly
- exercise skill and care in the performance of their work.

In return **employers** have an obligation to **their employees** to:

- pay agreed wages for duties performed or which the employee is ready to perform
- take reasonable care for the safety of the employee including as set out in current health and safety legislation
- provide a safe working environment and take reasonable steps to ensure the employee's safety (9)
- act in good faith towards the employee
- not act in a way so as to undermine the trust and confidence of the employment relationship
- behave reasonably towards their employees
- not to cause psychiatric harm to an employee by reason of the volume or character of the work imposed on the employee (10)
- not sexually harass an employee or racial discriminate against them. (11)

These duties exist **whether or not they are written down in the employees' contract of employment,** and exist over and above the statutory and other rights arising from the written contract.

4.3.The duty to follow lawful instructions

The crucial obligation that this handbook is concerned with is that requiring an employee to work in accordance with the lawful

contractual instructions of the employer. As this handbook explains, this obligation may be challenged in certain circumstances:

- **where an instruction is unlawful** - for example requiring drivers to drive road vehicles they are not qualified to drive
- **where an instruction is clearly unsafe** - either in breach of a statutory requirement or obviously a serious health and safety risk
- **where an instruction conflicts with statutory rights and obligations** - for example insisting staff breach anti-discrimination legislation or the Working Time Regulations 1998
- **where an instruction is outside the employer's contractual authority** - for example imposing obviously and intolerably unfair requirements on employees
- **where there is insufficiently direct instruction** - for example where there are conflicting instructions from different managers

and most importantly for this handbook

- **where an instruction conflicts with implied contractual duties** - especially the individual's duties of care or with a Code of Professional Conduct which sets out the specific duties of care for a particular profession.

The rest of this handbook primarily considers what to do when staff find themselves in such circumstances.

Summary

This chapter examines the "the duty of care", the status of a Code of Professional Conduct, the "public interest", what constitutes negligence, and whether or not a Code of Professional Conduct may be regarded as part of the contract of employment.

5. The duty of care, the public interest and Codes of Professional Conduct

5.1.The duty of care

All individuals owe a duty of care to each other. Health service employees must exercise that duty of care:

- to patients
- to colleagues
- to themselves

The courts have made it clear what standard of care can be expected of any individual. It is the standard of a "reasonable man or woman". Failure to exercise the duty of care to that standard can lead to a charge of negligent behaviour - defined as failure to take that degree of care which was reasonable in all the circumstances of the case or failure to act as a reasonable person would act.

For a some workers (such as a health professional), the courts have gone further and said that in determining whether a duty of care was exercised, the standard of work should be of:

"the standard of the ordinary skilled person exercising and professing to have that specialist skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the

ordinary skill of the ordinary competent man exercising that particular art". (12)

In other words, a nurse, technician, scientist, doctor, paramedic or therapist does not have to be the best there is, but must be at least at the standard of the reasonably competent practitioner.

The duty of care to a patient exists from the moment a patient is accepted for treatment or a task or role is accepted and the patient begins to receive services. This may be, for example, on admission to a ward, acceptance onto a caseload, when accessing NHS Direct or once registered at an A and E department. The ordinarily competent skilled person is expected to:

- keep their knowledge and skills up to date
- provide a service of no less a quality than that to be expected based on the skills, responsibilities, and range of activities within a particular trade or profession
- be in a position to know what must be done to ensure that the service is provided safely
- keep accurate and contemporaneous records of their work - for clinical professions there will often be specific guidance on this issued by the state registration body
- not delegate work, or accept delegated work, unless it is clear that the person to whom the work is delegated is competent to carry out the work concerned in a safe and appropriately skilled manner
- protect confidential information except where the wider duty of care or the public interest might justify disclosure

Any working arrangements or proposals for service delivery and resources must ensure all these requirements can be met.

Example: Inappropriate delegation to an OT assistant

The number of new wards opened has increased the workload of the Trust Occupational Therapy Department. With sickness and previously booked annual leave adding to the problem, a backlog of patients waiting for assessments has developed. A number of patients have been waiting for over two weeks and one in particular, who needs a bath board following a hip replacement, has just phoned again to complain about the delay and is threatening a formal complaint.

All the registered staff are already working with patients but there are two Occupational Therapy Assistants working in the office. The manager reluctantly decides to send one of the OTA's out to carry out the assessment. The OTA did this to the best of her ability but, when the bath board was fitted, and the patient tried to use it, it became apparent that the assessment has been inadequate. The contra indications of using a bath board following a hip replacement were not addressed by the OTA. Although the bath board was fitted correctly, the bath itself was too low and an attempt by the patient to use the bath board could result in the new hip dislocating

Issues. The delegation of tasks should only be done when those to whom the tasks are delegated are competent to undertake them. Although the manager was under pressure to help the patient before a formal complaint was made, the assessment should only have been carried out by a qualified member of staff, in accordance with the British Association of Occupational Therapists Code of Professional Conduct.

If it was impossible to get cover through a locum qualified OT, or to reallocate the work of a qualified OT, then the patient should have had the situation politely explained to him, including the right to complain if necessary.

The OTA should not have agreed to undertake the assessment knowing she was not qualified to do it, and should have explained that to the manager and if necessary to her union representative.

5.2.Negligence and the duty of care

Three criteria must be met for negligence to be proven and be actionable in the courts:

- the duty of care must actually be owed
- that duty must have been breached
- harm must have been suffered as a result

Whether negligence has occurred is a matter of fact for the courts to decide. Where the duty of care has been breached because the acts or omissions of a health care worker fell below those of the "ordinarily competent" health care worker, it is important to bear in mind that it will be no defence to argue:

- **the shortcomings occurred because of one's inexperience.** If the task or

circumstances required a person of a particular skill or standard, then if someone was too inexperienced to practise safely, they should have made that clear to their line manager or senior professional. In turn the supervising professional should have taken responsibility for checking that tasks are only delegated to, or undertaken by, competent persons. (13)

Example: Pharmacy technician taking on an extended role

Barbara is a pharmacy technician. She returns to work after a year long absence following a serious road accident. Her role had included an extended role in the final checking of dispensed medicines. She had had the appropriate qualifications and experience prior to taking on the role and had started her new role two months before being off. It had been agreed that on her return she would have a refresher period followed by an assessment of her continuing competency.

Due to staff shortages and sickness absence, the refresher period was condensed to one week and she was asked to recommence the full range of duties for a couple of weeks until the sickness absences improved. Although she had some reservations, she agreed. She soon felt under pressure as she had to refresh herself as she went along and at the beginning of the second week, missed two dispensing errors, one of which was quite serious.

Issues. It is the responsibility of the pharmacy technician, and of Barbara's manager, to ensure she is properly trained, up to date and competent to perform the tasks she is required to undertake. In this case, notwithstanding the staff shortages (perhaps especially because of them) she should not have been asked to resume the extended role without a proper refresher course and an assurance she was competent.

Staff of any occupation have an obligation to ensure they are competent and that must include ensuring they are up to date. Barbara should have sought advice and insisted on additional refresher training and support, however pleased she was at being back at work, or however nervous she was at appearing not ready to resume the full range of duties. (14)

- **the shortcomings occurred because one was acting under instruction.** An instruction requiring one to work unsafely either by act or omission is one that should be questioned and challenged. Pointing the finger at one's manager or another professional does not let you off the hook. It simply implicates that other person as well. Bear in mind that in any case where harm may have resulted, it is not unknown for the person issuing the alleged unsafe instruction to deny this happened.

Example: Health visitor and vaccination

A Clinical Medical Officer (CMO) asks a newly trained health visitor, Carol, to assist in a vaccination session because the experienced health visitor is off ill and the clinic is about to start. The health visitor has had no vaccination training, nor is she authorised to undertake vaccinations.

Carol fails to ask if the child has already had this particular vaccination and after she has done it, discovers that the child has, indeed, already (four weeks ago) had the same vaccination. Fortunately, the child suffered no physical after effects

Issues. Where a particular skill is required it is essential that the person undertaking that task or role has been trained and has kept herself up to date. The CMO should not have asked the health visitor to assist, but, in any case, the health visitor should have refused. Even if she had had vaccination training in a previous role, Carol would have been required to have ensured that she was up to date with the Trust's protocols and any recent clinical developments. Had the child suffered harm she could have been sued for negligence and reported to the Nursing and Midwifery Council. As it is she is likely to be disciplined

- **The shortcomings occurred because of inadequate resources.** This is especially the case where there is no evidence that any concerns about inadequate resources were formally identified and drawn to the attention of an appropriate manager. Pressure of work and excessive workloads are not, in themselves, a defence against negligence.

Example: Healthcare assistant making mistakes through staffing shortages

On a ward there has been one staff nurse and one Health Care Assistant short on the day shift for three weeks. The Trust claims to have tried to get agency cover but staff believe they have not tried very hard because they are over-budget for this quarter.

For the last three days there has been a further Health Care Assistant missing due to sickness. The one remaining day shift HCA, Dulcie, tried her best but by the end of the first day was aware that even with help from the registered nurses, it was impossible to carry out even the minimum of necessary duties to a reasonable standard. She raised her concerns informally with the ward sister who assured her they were trying to get cover, but said that with support from the registered nurses, it should be possible to keep going for a couple more days.

On the third day the Dulcie makes a mistake. She gives a drink to a patient who was designated "Nil by Mouth" and due to be operated on later that day. Dulcie is warned she faces a serious investigation. She is very upset.

Issues. In this case, the HCA should have found a way to put her concerns in writing so there was no doubt how serious the situation was. Dulcie's steward could have assisted with drafting a short letter.

In turn the ward sister, despite the pressures on her, should have acknowledged her responsibilities under the NMC Code of Professional Conduct and have redoubled efforts to get immediate cover, have sat down with the staff nurses and HCA to look at what the pressures were, what the risks were, and have considered what immediate steps could be taken - for example the temporary transfer of staff from another ward, or even the closure of beds. She should have immediately drawn her own manager's attention to the concerns expressed.

The HCA's UNISON representative should try to establish how long the situation has been developing, what steps have been taken, when managers became aware of the situation and

insist on an audit of other wards, or even run a quick confidential survey to establish the scale of the problem.

Dulcie should have found the courage to raise her concerns formally if nothing happened when they were raised informally. However she alone cannot be blamed if others failed in their duty of care. Clinical Governance should mean the focus of any investigation is at least as much on the staffing shortages and why they weren't tackled, not on one mistake by the HCA.

It is worth noting that in each of these three cases, there are clear responsibilities on other staff, especially those in managerial or more senior professional positions.

Tasks should not, for example, be delegated to staff too inexperienced to carry them out. Instructions to work unsafely will reflect on those who gave them, not simply on those who carried them out. Managers or other professionals expecting or instructing staff to carry out responsibilities where there are inadequate resources (of whatever kind) to carry them out safely, are themselves in breach of their duty of care.

If any manager or professional who allows or insists that such steps be taken is themselves registered, then they may expect to be called to account by their regulatory body as well as by their employer. If negligence is alleged they may be called to account by the Courts as well.

It will, for example, be no defence in turn for such staff or managers, to claim that they "did not know" staff had inadequate resources to work safely, if they might reasonably have been expected to know that the resources available were inadequate and potentially unsafe. This is especially so if they had been alerted to concerns on this by the staff in question - even more so if the concerns were identified in writing.

Nor is it any defence to argue that "the team" were negligent, not the individual. In law there is no such concept as "team negligence". (15)

5.3.What are the obligations of the NHS employer to provide services?

It is important to be clear what the responsibilities of the employing Trust are

where there are inadequate staffing resources or equipment. The obligation of the NHS or any particular part of it is not to provide the highest possible standards of care for all who need it. It is threefold:

- **to provide a comprehensive and integrated health care service**
- **to demonstrate that, within the available resources, appropriate priorities are chosen and**
- **to ensure that those providing care are able to practise safely and carry out their duty of care (and that of the employer) to each patient**

A whole range of protocols, standards and clinical policies have been developed to assist that process. Alongside them is a range of NHS human resources policies, some based on statute and case law, which seek to complement these clinical policies and assist in making the most effective use of available resources.

As a result, just because an employee or employer cannot do everything that they believe needs to be done, does not mean they have breached their duty of care. There are not limitless resources in the NHS or elsewhere. The obligation of an employee and employer is to:

- **ensure that what is actually done is done safely and appropriately**
- **make clear what cannot be done, or at least be done safely**
- **ensure the patient is treated with the appropriate urgency (16)**

There is one other reason why managers, including the Chief Executive, would do well to create an environment in which staff can practise safely. It is not only the employee who may be liable in negligence under such circumstances. The employing trust or other NHS employer will be held vicariously liable for any breach of the duty of care owed. This means that when damages are sought through a negligence claim it will be the NHS employer who has to pay damages not the individual member of staff whose acts or omissions may have caused the injury or damage. The employee may lose her/his job, reputation and registration, but it will be the employer who will be sued for damages. Moreover the Courts (and Ministers) have taken an increasingly serious views of failures of health and safety management.

Example. Chief Executive lost job following health and safety prosecution

One Southern England NHS Trust was served with a Health and Safety Inspectorate Notice following their failure to have a Health and Safety policy in place as required under the Health and Safety at Work etc Act 1974. The public furore (and ministerial displeasure) was such that the Chief Executive lost his job.

5.4.What are the obligations of the NHS manager in providing services?

NHS managers have four distinct duties:

- they have duties as employees in the same way as other employees have, **to follow lawful and reasonable instructions**
- they have a **duty of care towards those that they manage**
- they have a **duty of care to patients and the wider public**
- they may have **duties as registered professionals** under the profession's Code of Professional Conduct. You should note that these latter duties continue to exist as long as the individual remains on the register, whether or not they are practising

In addition all NHS managers in England are covered by a NHS Managers Code of Conduct, extracts from which are reprinted in Appendix 3 of this handbook. (17) This Code is intended to set out standards for senior managers as part of their contract of employment and addresses some of these themes. It is incorporated into the contracts of employment of senior managers. A similar Code has been issued for Wales. Trusts are expected to ensure private sector managers of health care services also observe the Code.

The introduction of clinical governance means that managers with responsibilities beyond the immediate delivery of a

particular clinical service may have a carefully defined duty to ensure that standards and systems are in place to ensure high quality. Large numbers of managers may also have clear responsibilities for ensuring that protocols and priorities identified by, for example, National Service Frameworks, are in place and adhered to.

Faced with potential or actual problems, a manager is expected to:

- identify why staff (or others) believe the situation is potentially unsafe. It will be crucial to sit down together with staff in an environment where staff are able to voice concerns.
- in the light of priorities set by the employer, the available resources and equipment, and protocols, determine what can be safely done. If the manager is not qualified in the occupation in question, s/he should take advice from an appropriately trained person who is. This may involve considering whether things could be done differently, but could also involve deciding certain tasks or roles will not be done until they can be done safely, or changing priorities for staff
- ensure that whatever steps are taken do not put staff who need to assess needs, in a position where they cannot do so, or cannot keep up to date, or maintain contemporaneous records.

The manager will need to manage staff in a manner which does not compromise the professional judgement of their staff or themselves. If this is not possible then s/he must inform his/her own manager in writing that a potentially unsafe situation exists, explain why, and seek advice. S/he will then need to ensure that the issues s/he has raised receive an early and appropriate response, which should be confirmed in writing.

5.5.The public interest

Another circumstance where the duty to follow lawful instructions may conflict with an implied duty in the contract of employment is where management instructions conflict with the duty to act in the public interest. Examples might include where a health service employee believes clinical practices are unsafe, where there is a serous risk of infection arising from unsafe equipment, or where fraud or waste is discovered.

In such circumstances, a member of staff

should normally draw their management's attention to their concerns, in writing. Every NHS employer should have a "whistleblowing" procedure to facilitate disclosure of sensitive information.

The legal rights of such staff to whistleblow are now much clearer following the enactment of the Public Interest Disclosure Act 1998, which protects workers in specified circumstances from suffering a detriment as a result of making disclosures about the acts or omissions of other workers in the public interest.

Someone making such a disclosure must do so in good faith (even if later it turns out to be untrue) and must believe that at least one of the following tests are met:

- that a criminal offence has been or is likely to be committed,
- that someone is failing, or will fail, to comply with legal obligations,
- that a miscarriage of justice will occur or has occurred,
- that there is a health and safety risk or there is a risk of damage to the environment, or
- that information about these issues has been, or is likely to be, deliberately concealed.

The Act protects all employees, contractors, trainees or agency staff. The legal protection is that he/she can receive unlimited compensation. However, to gain the protection of the Act it is important to ensure that any whistleblowing meets the criteria of being a "qualifying disclosure" and must be to a legal adviser, employer, Minister of the Crown, or a person prescribed by Order eg Health and Safety Executive. Only in more extreme circumstances are wider disclosures permitted. (18).

NHS employers have separately been instructed to set up "whistleblowing" procedures and ban gagging clauses. Your Trust should have one and you have a right to ask for it.

Example: Bristol - why failure to blow the whistle cost babies' lives

Surgeons in Bristol continued carrying out heart operations on babies using methods that were obviously dangerous. A very high proportion of babies died. Parents were not told the risks. Many health service staff knew there was a problem but only one - an anaesthetist - tried to formally raise concerns. He paid the price by being driven out of his profession in the UK and ended up working in Australia. No one else formally complained. It is very likely that the failure of doctors, nurses and other staff including the most senior managers, to raise concerns - whether from fear or otherwise - led to unsafe practices continuing much longer than they should.

Issues. The public outrage at the Bristol baby deaths was such that an independent inquiry led by Professor Kennedy (19) resulted in a scathing report and a serious attempt at root and branch reform of some aspects of the medical profession. Yet the failings of other health service staff was as serious. Why did no nurse blow the whistle? Why did senior managers do nothing?

Since Bristol, every NHS employer is supposed to have a rigorous Clinical Governance framework in existence allied to a Freedom of Speech procedure.

Yet on a less dramatic scale, it remains very difficult to challenge poor practice, especially when carried out by a more senior health professional or condoned by a senior manager. It can take great courage to break ranks and suggest that a respectable doctor, nurse, therapist, scientist or other colleague, is responsible for poor or unsafe practice. The personal price can be very high.

Yet finding that courage is essential. Silence makes one an accomplice. Whatever the reasons for the poor or unsafe practice, Codes of Professional Conduct, the duty of care and the wider public interest (never mind a clear conscience) make it essential to find a way of making one's concerns known.

Most importantly:

- your employer will have a local Freedom of Speech procedure with an independent element to it
- you must carefully and professionally document your concerns
- you should talk through your concerns with your steward and, normally, with a Regional officer - especially taking advice on how to take matters forward - before going public with any accusations.

5.6. Codes of Professional Conduct

Professional Codes of Conduct exist to set standards to be applied to those wishing to become and remain members of a profession. In one sense they simply "codify" aspects of the duty of care and standard of care within a framework of values and principles for specific occupations. In other respects they may go beyond the duty of care and serve a wider purpose linked to the public interest. The Codes themselves are often elaborated in other statements, which seek to expand or clarify the basic principles.

They have often set out specific guidance on dealing with circumstances where the duty of care may be compromised. For example:

"as a registered nurse or midwife, you are personally accountable for your practice and.....you must act to identify and minimise the risk to patients and clients"

Nursing and Midwifery Council Code of Professional Conduct

A breach of any profession's Code of Professional Conduct carries the risk of suspension or removal from the professional register. Where the profession is a state-registered one, then removal from the Register makes it unlawful for you to practise in that profession, and unlawful for any employer to employ you in that professional role if you are removed from the Register.

State registration of healthcare staff

Where the profession is not yet state-registered then the damage to reputation and livelihood may not be so serious. However, the government has made it clear that it intends to introduce some sort of regulatory framework for the large majority of NHS staff. The revised Health Professions Council will include substantially more professions than before and UNISON has actively supported some of those groups in getting a regulatory framework for their work.

Occupations such as healthcare scientists, including clinical physiologists, perfusionists and critical care technologists, as well as pharmacy technicians, clinical psychologists, ODPs and counsellors will certainly gain some sort of state registration in the near future. Others will follow, including healthcare assistants. Recognition as a registered profession assists in providing protection to the public but also enables staff to argue more forcefully against unsafe protocols or unsafe working environments, and is to be welcomed.

5.7.The status of Codes of Professional Conduct

Some Codes of Professional Conduct recognise there may be contractual implications arising from the Code. Thus:

"subject to any legal requirements to provide a minimum service, if the basic standards of treatment and intervention cannot be met at any time, for whatever reason, Occupational Therapists should decline to accept a referral or initiate a treatment"

Code of Ethics and Professional Treatment for Occupational Therapists Para 3.1.2.

and

"You are personally accountable for your practice. This means that you are answerable for your actions and omissions regardless of advice or directions from another professional"

Code of Professional Conduct Para 1.3 Nursing and Midwifery Council

Both those requirements, for example, might lead a registered professional to refuse to accept an instruction from a manager or senior professional.

Student trainees - their responsibilities - cardiac physiologist and student nurse

Due to staff shortages a trainee cardiac clinical physiologist Eleanor is asked to undertake stress/exercise tests without there being supervision by trained staff. The results of the tests were mis-read. Clinical physiologists are not currently state registered but will be in the near future.

Whilst on placement in an A and E department on a busy afternoon shift a student nurse, Fazia, is asked to look after a patient who had been admitted with a possible Cerebral Vascular accident. The RGN came from time to time to monitor treatment but the student was left for long periods unaccompanied to monitor his input and output and ensure his intravenous fluid was running to regime.

Issues. There is sometimes confusion over the accountability of student and trainee staff. Trainee and student staff cannot be professionally accountable in the way that fully trained and (where applicable) registered practitioners are.

They are not expected to reach the standards of the "ordinarily competent" practitioner and should never be asked to work except under the supervision of an appropriately qualified member of staff. The student or trainee should always make it clear that they are not yet qualified, and in turn a patient has the right to refuse to be treated by you.

As training increases students and trainees are not always be directly accompanied or supervised. However students and trainees must not participate in any procedure for which they have not been fully prepared or adequately supervised. Though not qualified, students and trainees do have a duty of care albeit the standard is less than that of a qualified practitioner.

Should a student or trainee be asked to undertake tasks they believe they are not qualified to do, they must make that clear, initially to their supervisor, and if necessary to their tutor of a more senior manager. That is what both Eleanor and Fazia should have done.

The supervisor (and training establishment) has a duty to ensure the student or trainee does

not undertake tasks or responsibilities they are not qualified to. Inappropriate delegation (whether by act or omission) is a very serious matter expressly dealt with in all Codes of Professional Conduct. Some registering bodies (eg NMC) issue specific advice to students and trainees.

Many NHS contracts of employment make it clear that a breach of a Code of Professional Conduct will be regarded as a disciplinary matter (though only the relevant professional body, not local management, can actually determine whether a breach of the Code has taken place). In such cases the Code may be regarded as being implicit within the contract.

Secondly, such case law as exists on the matter suggests that Courts may assume that statutory Codes are incorporated into contracts of employment where state registration is a pre-condition of employment. In the landmark case of nurse Graham Pink, for example, the defending barrister John Hendy QC claimed that Stockport Health Authority's decision to settle the case, and at the maximum level of compensation, strongly suggested they accepted this was indeed the case.

A Code of Professional Conduct may certainly be taken as a norm against which employee practices may be measured. Moreover, any orders or instructions by an employer deviating from this norm need to be justified.

It is reasonable to assume that any Code of Professional Conduct issued by a statutory regulatory body is implicit within the contract of employment in the same way that the duty of care is. If this is the case, then a member of staff believing they are instructed to breach their own Code may reasonably conclude that this is an unreasonable instruction which should be questioned and challenged.

Finally, the Code is a document against which any alleged professional misconduct will be judged.

For all these reasons, any contractual instruction which requires a state registered professional to breach their Code of Professional Conduct should be regarded as an unreasonable one and likely to be unlawful. In such circumstances, the

practitioner's obligations to their Code takes precedence over their obligation to obey a conflicting instruction.

It is worth noting that a registered professional is still bound by their Code of Professional Conduct even if they are not practising. As a result they can still be held to account by their statutory body for misconduct as long as they are on the professional register for that profession.

In any case, anyone covered by a statutory registration will already know that the consequence of losing one's registration is potentially more serious than losing one's employment. Loss of registration prevents you practising that occupation anywhere in the UK, not just with your current employer.

5.8. Implications of not being employed by the NHS

Many people contribute to healthcare provision but are not employed by the NHS.

In particular, healthcare staff employed by the voluntary and private sector - including in residential and nursing homes, by private hospitals, by private contractors and by GP practices - are in theory increasingly subject to the same framework of health policies, clinical governance and inspection. The reality is that the inspection and contract compliance regime is patchy, and employment practices are often much worse, without even trade union recognition.

All of the framework set out in this handbook, setting out the implications arising from the duty of care and from professional accountability, apply whatever the employment setting. Those implications also apply to agency and temporary staff whatever the employment setting.

The significant difference is the absence of a detailed framework of clinical governance and good employment policies, including union recognition, which means the non-NHS sector is often less well regulated, and that in practice it can be much harder to raise concerns about patient or staff safety.

It is worth noting, however, that GPs are bound by the GMC Code of Conduct and that the Code of Conduct for NHS Managers applies to private contractors.

Staff seeking to raise concerns in those settings are strongly advised to take advice before doing so.

Positively influencing decisions about service priorities and staffing

There are several ways to influence decisions about service priorities and resources before they have a direct impact on patients and staff. Real Partnership Working should mean trade union involvement in the strategic planning process. It should mean trade union involvement at the stage when the problem is being defined, not simply once an answer has been decided. (20), (21)

It is also worth using non-Executive members of Trust Boards to keep informed and to lobby. Where staff believe inappropriate priorities are being set or unrealistic expectations being determined without increasing the staffing resources available, then the sooner concerns are raised, the better.

It is also well worth developing links between the trust trade unions and local patients' organisations and local councillors, who may have a direct interest in campaigns to ensure safe practice.

For more information, it is worth checking out the UNISON Positively Public web site at http://www.unison.org.uk/positivelypublic, which contains information about the role of the private sector in healthcare.

Summary

This chapter summarises some of the statutory rights and duties which may be useful when staff are seeking to ensure working practices are consistent with their various duties of care.

6. Statutory rights and duties which may conflict with management instructions

6.1. Statutory rights and the contract of employment

The requirement in a contract of employment to follow management instructions is to follow "lawful" instructions. Employees cannot agree to give up their statutory rights, nor should they agree to undertake unlawful instructions.

Some years ago, it was not uncommon for employees to sign a statement giving up their right to sue the employer in the case of an accident at work. The Courts held that such a requirement was unlawful.

There are a number of specific statutory rights and duties, which might conflict with management instructions:

a. **S.7.a Health and Safety at Work Act (HASAWA) 1974** sets out the employee's duty:

"to take reasonable care for the health and safety of himself and of others who may be affected by his acts or omissions at work"

An instruction that requires an employee to do otherwise is not reasonable and may be unlawful. It is important that a judgement about the application of this is made in the particular context of each situation. Employers have sought to argue that it is necessary to balance the safety of patients against those of staff. If this happens then it is crucial to take advice from your trade union official. There continue to be too many cases where employers have sought to refuse responsibility for harm caused to health service staff arising out of and in the course of their duties.

Porter asked to move a heavy patient

A 20 stone patient is being moved between wards and then into bed. On arrival in the new ward, there is no mechanical assistance available to help move the patient into bed. The staff nurse says she's reluctantly prepared to try to manoevre the patient with the porter, but the porter, George, is concerned. A colleague recently hurt himself and a patient trying to do something similar. A discussion starts and the ward sister, who is under pressure to find two more beds urgently, joins in. She implies that George is being obstructive and asks them to "get a move on please" as they are already short of staff on this ward.

Issues. An epidemic of back injuries caused by unsafe lifting has affected NHS staff. It was well recorded and has led to the NHS issuing specific guidance setting out good practice. George is right to be concerned. If it is not safe he should not be doing it and should not be put under pressure to do it.

George should confirm that he was not properly equipped to do the task. The patient should not be lifted without a hoist. The Trust should have a local procedure for lifting and handling patients and these should be followed strictly. If the procedure says that 20 stone patients can be lifted without hoists by the use of several personnel who have been adequately trained in lifting and handling procedures then that is the procedure that should be followed.

Meanwhile the ward manager should be asked by the UNISON steward to remind all staff on that ward that there is a Trust policy, it should be followed, and ensure that all staff have been trained in following it. (22)

b. **S.2 HASAWA 1974** sets out general duties of employers to their employees to ensure, so far as is reasonably practicable:

"a. the provision and maintenance of plant and systems of work that are safe and without risks to health

"b. arrangements for ensuring safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances

"c. the provision of such information, instruction, training and supervision as is necessary to ensure (their) health and safety at work

"d. as regards any place of work under the employer's control, the maintenance of it in a condition that is safe and without risks to health……

"e. provision and maintenance of a working environment that is safe, without risks to health…..".

Cutting the corners on hospital cleaning.

Due to a flu outbreak, the number of cleaners in a hospital block with four wards is 50% down one evening. The supervisor of the contract cleaning company says that no help is available so they'll just have to do their best, but she'll try to get some cover the following evening. The next night, the situation is the same. Two of the cleaners, Harriet and Hazel say they are not prepared to work like this as it is impossible to keep the wards clean and they have asked to meet the ward sister that evening with a list of work not done the previous evening. The manager tells the supervisor to let them know they could be disciplined if they do that.

Issues. There is plenty of evidence that shoddy cleaning by contractors has led to outbreaks of MRSA seriously (and sometimes fatally) affecting patients. If they feel able to do so despite the threat of disciplinary action, the cleaners should make their concerns clear verbally and in writing, to the Supervisor and to their line manager. They should make it clear that they are concerned at the standards of cleanliness and their inability to maintain clean areas/wards because of the shortage of staff. They should state which areas they have been unable to clean properly and ask that the Ward Sister and Hospital Management be informed.

Harriet and Hazel should also state that they are raising the issue with their UNISON steward as they believe the contract between the hospital trust and the cleaning company is not being fulfilled and they are concerned for the safety of patients, staff and visitors. They should ask for assurances from the supervisor and manager that the issue will be raised with the ward sister and hospital management and that they will be advised of any decisions as to how to proceed in the event of continued staff shortages.

Alternatively, if they believe the threat of disciplinary action and worse is a real one, they may prefer to raise all of the issues above in writing with their UNISON representative and ask the representative to pursue the matters on their behalf. It may be that the trust will be up in arms at the sloppy performance by the contractor. Either way, keeping a careful record of concerns and finding a way of raising them is essential, even if Harriet and Hazel have to remain anonymous.

c. **The Employment Rights Act 1996** prevents workers being victimised where they take action to avert immediate dangers to health and safety.

d. **The Public Interest Disclosure Act 1998** protects workers who “blow the whistle” on their employer’s malpractice in specified circumstances where this threatens the public interest. The Act encourages the use of internal procedures first, and is complemented by the procedure every NHS Trust is expected to have in place to ensure the Act is followed.

e. **The Occupier’s Liability Act 1975** sets out the duty owed to employees and visitors by the owner of premises. For NHS staff this may not always be the local NHS trust but could include a GP practice, a church hall, council premises and so on. If an NHS worker is required to work in premises which may be unsafe, or uninsured, then there may be a conflict between that instruction and the duty of

care to themselves, colleagues or those they manage.

f. **The Management of Health and Safety at Work Regulations 1999** require employers to make a suitable and sufficient assessment of health and safety risks.

g. **The Working Time Regulations 1998** and the linked agreements on its implementation within the NHS set limits on the long hours culture, which permeates the NHS. Bear in mind that the NHS has agreed that the Regulations apply to all NHS staff.

h. **The Race Relations Act 1976** as amended by the Race Relations (Amendment) Act 2002 makes race discrimination illegal and places obligations on employers (and staff and trade unions) both in relation to employment rights and service provision.

i. **The Sex Discrimination Act 1975** as amended by the 1986 Act makes discrimination on grounds of sex or marital status illegal.

j. **The Disability Discrimination Act 1995** makes it illegal for an employer with more than 15 employees to treat a disabled person less favourably, because of their disability, than they would someone else. It also prohibits discrimination in services. The DDA is increasingly referred to in cases where NHS staff have been off sick from work and then seek to return to work

There are a raft of policies within the NHS to apply both the Health and Safety obligations placed upon employers, and their equal opportunity duties. The main ones can be found on the DoH, Scottish Executive, Welsh Assembly and Northern Ireland Executive web sites which can be accessed via the UNISON web site.

Example: Stress at work - the case of Richard Pocock

Richard Pocock was a mental health nurse in Colchester, Essex. He was subjected to a vindictive, ruthless and macho style of management. He had worked happily for 17 years at Severalls Hospital until November 1994 when it became apparent that the threatened closure of his ward was being brought forward. He was told his job would go and he must

apply for other jobs. However, he was not qualified for the only other jobs available.

He was placed in a managerial job for which he was unqualified and advised it would look bad for him if he refused it. He was unable to cope with the job and then failed at interview for another managerial job. His behaviour had changed from being a solid and dependable character to one displaying erratic and irrational behaviour. Richard's employers failed to spot the signs of acute stress and thereby contributed to the tragic consequences that followed. Richard then committed suicide leaving a widow and three children.

A consultant psychiatrist examining the case for UNISON told the court that Richard's death was an entirely foreseeable result of the activities of more senior management. North East Essex Mental Health Trust were ordered to pay a £25,000 settlement to his widow for being in breach of their duty of care to Richard.

Issues. The impact of bullying and stress at work has become a major concern. Research commissioned by the NHS has demonstrated how widespread stress is (23) whilst NHS research has shown there to be an epidemic of bullying and harassment at work. (24)

Case law is constantly changing but some principles are clear:

- employers do have a duty of care towards employees which may well be breached by bullying and stress at work
- it is essential that the employer is informed in writing of any concerns held, otherwise employers may claim they didn't know about them even if they should have

Excessive workloads, inappropriate delegation and a macho management environment are all causes of stress and bullying and it is essential to:

- keep a careful record of events - such as a diary
- take advice from a UNISON steward sooner rather than later
- put your concerns in writing
- see if it is possible to challenge these pressures as a group rather than individually

Employees are protected by statute against victimisation for exercising their rights under Equal Opportunities legislation, rights arising from undertaking TU duties and activities, and rights arising from their role as Health and Safety representatives.

Summary

This Chapter summarises how clinical governance may assist in highlighting and tackling concerns about the duty of care.

7. Clinical governance and the duty of care

7.1.The moves to clinical governance

In the wake of public concerns about a series of medical scandals, the government signalled a shift towards:

- improving the detection of adverse events
- avoiding risks
- open investigation and learning of lessons
- a "no-blame" culture wherever possible
- better sharing of good practice and bad experiences

This approach was called Clinical Governance and was intended to ensure standards were improved across the NHS, with an end to the cover-ups and secrecy that were discrediting health staff and the NHS itself. It was defined as:

"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".(25)

In each of the four UK countries, a system was developed which would ensure in each trust that there were:

- clear lines of responsibility and accountability for the quality of health care
- clear policies to manage risk and published procedures for each staff group to identify and correct poor performance
- a comprehensive set of quality improvement systems

In turn these programmes would require:

- local arrangements for monitoring and improving the quality of health care

- the involvement of staff at all levels in conducting a baseline assessment of quality and in developing procedures to improve it
- national bodies which will inspect local trusts, conduct national reviews of particular services, and produce and disseminate clinical guidelines

The Department of Health, for example, has set out a series of "Essence of Care" benchmarking standards. They are down-to-earth and explicit about what "good" care involves. (26)

Pre-conditions of effective clinical governance include:

- competent clinical supervision
- appraisals carried out by trained staff
- resources and protected time for training and continuing professional development, including for part-time and shift workers
- genuine team working in which concerns and suggestions can be raised openly by any staff members

Clinical governance, implemented properly, has the duty of care and the public interest at its core. It will seek to have in place tools to ensure this is the case and that staff skills and staffing levels are appropriate and are steadily enhanced through training and professional development.

Clinical governance is long overdue. The Health Act 1999, in making quality of service a core duty of NHS Trusts, will rely partly on clinical governance to ensure there is a welcome corrective to the previous key duty of NHS trusts - to balance the financial books.

7.2. The implications for challenging or influencing management decisions

Clinical governance "builds on and strengthens the existing systems of professional self-regulation." Equally, an open, learning organisation requires a greater ability to highlight staff concerns about obstacles to safely delivered services such as excessive workloads or stressed staff. Clinical governance also requires regular appraisals of staff and a genuine programme of continuing professional development for all staff.

Clinical governance should therefore make it significantly easier to raise staff concerns both prior to service developments and when management instruction, or the working environment, undermine the duty of care.

Impact on disciplinary procedures (emphasis on improving and learning from mistakes, not punishing)

The ACAS Code of Practice on Disciplinary Practice and Procedures (26) encourages employers to use disciplinary procedures as a means to improve performance rather than a means of punishing workers. Many NHS Trust procedures contain a similar principle, though this is not always the spirit in which disciplinary action is undertaken.

When dealing with clinical issues (in their broadest sense) it is now essential that this principle is clearly stated and acted upon. Many so-called clinical shortcomings arise from excessive workloads, inadequate staffing levels, inappropriately delegated tasks or roles, or an unacceptable bullying management culture. Trusts are supposed to be working towards a no-blame culture in which mistakes can be honestly acknowledged and learnt from, rather than seized upon as an opportunity to punish.

It is therefore essential that concerns about safe practice are recorded and drawn to the attention of appropriate persons at the earliest possible opportunity. It is equally important that the principles of clinical governance are placed at the heart of any changes to services and systems.

Summary

There is now in place a comprehensive range of policies, which should help staff and managers ensure the duty of care and the public interest is protected. These policies vary slightly between England, Scotland, Wales and Northern Ireland, but are essentially the same.

8. How NHS employers are supposed to treat staff

8.1. The new policies

These policies derive from:

- statutory employment rights
- the duty of care employers owe to their employees
- decisions about what constitutes good employment practice to improve recruitment, retention, morale, flexibility, good work practices and so on
- the need to implement clinical governance

Several of these policies directly influence the ability of staff to question and challenge management instructions:

- a ban on gagging clauses, and unnecessary confidentiality, and the implementation of whistleblowing procedures
- a social partnership approach to involving staff in planning and delivering healthcare with a local policy on staff involvement
- policies to tackle harassment of staff by other staff, managers or members of the public
- adoption of a wide range of policies seeking to balance work and family responsibilities - such as the Improving Working Lives initiative in England or the PIN set of policies in Scotland
- a cut in the use of fixed term contracts

which can make staff nervous about raising concerns

These are all policies health service staff will welcome. They should make it easier for staff to be pro-active and insist that concerns about safe working, the duty of care and Codes of Professional Conduct are built into changes in working practices or service provision. Some examples are given in the next Chapter.

Clinical governance itself is as much about employment policies as clinical care, and the new HR policies and clinical governance should be understood in tandem.

Equally, these policies should be used alongside developments in the law and research on issues such as the handling of stress at work.

Treating staff better improves patient care

Detailed research, commissioned by NHS employers, has demonstrated conclusively that:

- differences in human resources practices account for 33% of the variation between different hospitals in deaths within 30 days of emergency surgery and deaths after admission for hip fracture
- the key factors were the extent of genuine appraisals and the extent of genuine team working based on co-operation, and clarity over autonomy and responsibility

The research demonstrated that these differences in mortality rates were directly linked to staff being clear about what they were required to do, and being valued by the organisation, both of which were especially linked to appraisal

The research also drew on research showing that almost 27% of the NHS workforce suffered significant stress in which the key factor was workload and that clear objectives, genuine participation, and an emphasis on the quality of patient care were good for the mental health of staff. (28)

Summary

NHS employers are under immense and conflicting pressures. The government wants rapid improvements in services, and has promised very large sums of money to achieve this. Yet the backlog in under-funding, staff shortages and shoddy buildings and equipment is so enormous that it is proving very hard to bring about improvements at the speed ministers, staff and patients want.

9. The pressures on NHS employers

9.1. Conflicting pressures.

Unfortunately, many of the pressures employers face are in conflict with each other:

- Ministers say they want a radical shift to a primary care led NHS with an emphasis on public health, but many of the **targets** set (such as cutting waiting lists and times) emphasise acute treatment.
- Ministers have raised public expectations since 1997 with repeated statements about the increased **funding** for the NHS but it is only recently that the funding is coming through on a really substantial scale, and much of this is tied to specific projects, not an overall increase in general funding.
- Ministers have pushed through long overdue Human Resources strategies for the NHS at whose core is the belief that only if staff are treated better will recruitment, retention and morale improve. Yet at the same time **the workloads and stresses on managers** have never been greater with astonishing turnover levels for senior managers.
- Ministers have stressed the importance of more flexible working and skill mix. However many employers are forced to **grade mix rather than skill mix,** to save costs or through staff shortages, leading to staff opposition. In other Trusts, whilst some **"modernisation"** has been done in an exemplary manner improving services and staff morale, in others it has been forced through at breakneck speed and with little evidence base.
- Ministers have stressed the importance of

good **Human Resources policies** but until recently have done too little to monitor and enforce good practice, leading to staff disillusionment. Moreover many smaller trusts have weak or understaffed Human Resources departments with too little power to insist on good HR practice. This is compounded by the fact that the formative years for many managers were under a Conservative Government when "tough management" was equated with good management and bullying was rife. For some, those habits are hard to break.

- Ministers have gone out of their way to stress the importance of staff ownership of local policies and service developments. However, pressures from ministers to deliver a multitude of targets in very tight **deadlines undermine a partnership approach**, which usually takes longer to develop a policy or service, but is more effective.
- Ministers stress the importance of **improved quality, openness and transparency** yet put immense pressure on local employers to increase the quantity of work undertaken without sufficiently funding the staff and equipment to allow that to happen. At the same time that Clinical Governance emphasises a "no-blame" culture, scapegoating and blaming continue apace with too many employers.
- The NHS has been subject to never-ending **organisational change** and mergers (and more is promised) despite the evidence that such changes destabilise organisations and take up an immense amount of management time.
- Ministers constantly proclaim the management skills of the **private sector** in a way that reflects badly on the NHS - and yet pays NHS managers far less than they could get in the private sector.
- Ministers have pushed through **PFI schemes** in England as a panacea for poor buildings and equipment yet privately many senior managers admit that they are saddled with huge debts and must devote vast amounts of management time to such schemes with little central support.
- Some of the **targets** set (waiting times and waiting lists, or ambulance response times) can easily have perverse side effects, distorting priorities or leading to "fiddled figures".

In combination, such pressures mean that many managers are themselves under pressure to deliver services with too little resources, introduce changes too quickly, and often have insufficient knowledge of good Human Resources practice or change management skills.

None of this means that poor management should not be challenged. What it does mean is that often managers themselves may be privately sympathetic to the issues their staff raise and that it may well be possible to work with them to tackle the sort of conflicts this handbook raises.

It certainly means that faced with an approach that emphasises the duty of care, the public interest and staff safety, it will be difficult for managers to simply ignore such issues.

Example: Managers have rights and responsibilities too

John is a Chief Biomedical Scientist in a microbiology laboratory. He is concerned that due to staff shortages and excessive use of Locum staff, morale is falling and workloads are steadily growing to the point where they are close to being unsafe. Staff at all levels are privately complaining and he has great sympathy but he simply cannot keep any permanent staff he recruits because of low pay and excessive workloads. The vacancy factor is 24%.

The UNISON steward, Julia, representing biomedical scientists, MLA's and other staff has been raising these issues, referring to the IBMS Code of Professional Conduct, which states

"All professionals, within their duty of care, have a responsibility to bring to the attention of their manager any difficulties that may be encountered in the performance of their professional duties"

Now the steward has given the Chief a written ultimatum - find extra staff or reduce the workload or the coverage. Julia has provided a detailed breakdown of how the staff shortages are affecting safe practice.

The Chief talks to his own manager. He says that whilst he sympathises, there is nothing that can be done in the short term.

Issues. John broadly accepts the points made in the letter from the steward. He is worried that unless something is done, there will be an overtime ban and more staff will go off sick, making things even worse.

Doing nothing is not an option. John should sit down with the staff to look at whether there are any ways in which the work could be covered more safely. He should then draw up an option list. Most obviously, the laboratory could temporarily withdraw its 24-hour cover except for minimal on-call. This would delay GP tests but not necessarily be life threatening. If that doesn't have enough impact he could seek permission to increase the number of Locum staff, since staff willing to work overtime are all working at least one shift extra a week already. If that doesn't work he will need to sit down with his manager and, if necessary in writing, identify what the options are that would ensure safe working, and spell out the risks if that is not done.

In the longer term, a serious recruitment and retention strategy should be put in place, linked to a strategic review of how laboratory services across the trust and beyond are provided.

If the Chief works like this, he and Julia, the steward, can be a powerful combination to gain additional resources.

Managers may find the Code of Conduct for NHS managers (see Appendix 3) a useful reference document.

Summary

There are effective and responsible ways in which individual members of staff or staff groups can, and should, challenge unsafe clinical and employment practices. This chapter explores some of them. Wherever possible the concerns should be tackled informally and jointly with management. Where this is not possible, this chapter explains other options.

10. How can instructions to work unsafely, and unsafe practices be challenged?

10.1. Three main challenges

There are three main circumstances in which NHS employees may find themselves needing to challenge management instructions to ensure their duty of care and the public interest are safeguarded:

- where there is a need to respond to an **unexpected event or emergency**
- where a **continuing hazard or poor practice** needs to be remedied and a long term solution is needed
- where **new services or new ways of delivering existing services** are being considered

There may be occasions when an individual health care worker has concerns which are not shared by all colleagues. If you are convinced you have genuine concerns then it is essential to raise them even if this makes you unpopular at the time. Taking the easy course may avoid short term pressures but is not appropriate or defensible if it harms patients, colleagues or yourself. Simply because colleagues are unwilling or afraid to raise concerns does not mean you shouldn't. Each individual health care worker has a responsibility to ensure legal duties are adhered to and registered staff must adhere to codes of professional conduct.

10.2.So what options are there?

Where there is an emergency of serious and imminent danger to themselves or others, then an employee may rely on the statutory protection offered to health and safety activities (29) to raise health and safety concerns or disobey an order by taking their own, appropriate, action or by refusing to work at all

The general duty of care and, where they apply to the staff in question, Codes of Professional Conduct, may be relied on where staff can reasonably argue that the duties imposed by Codes of Professional Conduct are themselves contractual or override contractual duties.

Both these steps may be underpinned by use of either the employers own "whistleblowing procedure" that all NHS employers are supposed to have in place, or where that fails or is cumbersome, the use of the Public Interest Disclosure Act which protects whistleblowers in specific circumstances with the threat of unlimited compensation if they are victimised.

Whichever course is appropriate, individual members of staff, and, where appropriate, the staff group collectively, must ensure they act in a way which highlights the precise problems, demonstrates the seriousness of the situation, and gives the NHS employer no option but to respond quickly and appropriately or run the risk of successful challenge and possible public embarrassment.

Example: Operating Department Practitioners and out of hours arrangements

A new out of hours arrangement is proposed for anaesthetic support for a new obstetric service. The proposal, as described to staff, requires the anaesthetic assistant for emergency theatres to also provide cover for the obstetric service. In the event of an emergency in the obstetric unit, the ODP, Ken, would be expected to attend, even if this meant leaving an anaesthetist with an anaesthetised patient in the emergency theatre.

Issues. Changes in working arrangements - on-call, shifts, equipment, or changes of location - often have consequences which could have been avoided if staff had been properly consulted.

- Ken firstly needs to ensure he has written confirmation of what is proposed.
- He then needs to set out why he (and hopefully ODP colleagues) are concerned
- He should seek advice both from UNISON and from his professional body the Association of Operating Department Practitioners with whom UNISON already works closely
- The advice from the AODP will draw Attention to Paragraphs 1 and 4 of their Code of Conduct which cover an ODP's responsibility for protecting the rights and health of patients, and not allowing any act or omission on their part to place at risk the care afforded to patients
- It is likely to further draw on any relevant professional evidence. This would include advice published by the Association of Anaesthetists of Great Britain and Ireland which states "The safe administration of anaesthesia cannot be carried out single-handedly. Competent and exclusive assistance is required at all times…..Assistance for the anaesthetist must be exclusive for any particular operating or investigational setting where anaesthesia is being administered".
- It might further draw on any research evidence that Ken, his colleagues or the AODP are aware of. In fact the 7th Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy provides supporting evidence
- The ODP would then set out these concerns in writing, seeking confirmation that there will not in fact be any foreseeable risk that might place patients at risk as a result of such a working arrangement. This is likely to mean changing the proposal
- By setting out the concerns in writing at an early stage and placing the onus on management to explain why this is an evidence based approach which has undergone a risk assessment, Ken gains the moral high ground and can protect both patient interests and his own.

Thanks to the AODP for this example, based on an actual and successful case combining their advice with the local work of UNISON.

10.3.How this should be done—individual action and collective measures

As explained throughout this handbook, each individual health care worker has a personal responsibility to ensure his/her duty of care to patients, colleagues, him/herself and the employer are observed, and that the public interest is protected.

That means each individual has steps they can and must take as well, as any collective measures that may be considered. Nervous members of staff should be encouraged to support any stand the union is taking by reminding them that the duty of care and the public interest are not issues they can opt out of. As one Code of Professional Conduct puts it (but it applies to all):

"Where you cannot remedy circumstances in the environment of care, you must report them to a senior person with sufficient authority to manage them....This must be supported by a written record". (30)

Note that:

- this is not an option, you "must" report concerns
- the report must be **in writing**

Whether or not their colleagues are concerned, if an individual health worker believes safe practise is at risk then they must highlight their concerns and at the least ensure appropriate management is aware of them.

Much better, of course, would be if your concerns are shared by other colleagues. In that case a collective response will be more appropriate and effective. In such circumstances, however, it is preferable that each individual member of staff endorses any statement of concern that is drawn up. Moreover, staff whose profession is regulated should note that a collective representation does not remove the need to personally identify concerns they may have as well.

On the other hand, it is crucial that an individual member of staff takes advice - from her colleagues, her steward, from her full time official, or her professional body. It is important to be clear:

- precisely what the concerns are
- whether they really are something that has to be formally recorded
- what the individual member of staff is seeking

It important to distinguish between matters that should be raised informally with local

managers and those matters that require a more formal approach. Where possible, concerns should be raised informally as long as this does not give an opportunity for unreasonable delays in tackling the concerns raised.

It may well be that the manager shares the concerns raised and actively seeks a written record that they can draw to the attention of their own manager. On the other hand, it may be that the manager seeks to dissuade the member(s) of staff from pursuing concerns. If the concerns are serious then, after taking advice, they should be placed in writing and pursued more formally.

Example: Excessive workloads - district nurses.

Laura, a district nurse (DN) is one of three based at a health centre. For the last couple of years all three have complained they are understaffed. Until two years ago there were four DN's covering this health centre and the number of elderly patients on their caseload has increased by 15% since then. One of the DNs leaves and her replacement is a part-timer working 3 days a week. The third DN then goes on long term sick leave with stress. The manager manages to find a District Nurse Assistant but says there are no monies to cover the qualified DN.

Laura is the last remaining district nurse. She believes this is unsafe and seeks advice.

Issues. Laura should:

- set down in writing why she believes this is unsafe, in particular recording how the workload and clinical demands have changed, what the risks are from the current staffing, and preferably identifying work she believes should be suspended in order to carry out priorities safely and/or identifying what additional staffing is needed to practice safely
- if possible discuss her views with her two colleagues, but irrespective of whether they are prepared to support her, should put her concerns in writing, quoting her NMC Code of Conduct and send them to her manager. If her manager is not a qualified community

nurse, she should copy her concerns to her lead professional. She should also send a copy to her union representative (she may want to send it as a "blind" copy at this stage). Appendix One contains a pro forma letter to be adapted. It is available electronically on the UNISON web site at www.unison.org.uk/healthcare/dutyofcare

- seek a meeting with her manager to discuss her concerns, but should ensure that her manager's verbal response is confirmed in writing. If the manager won't respond in writing then the member should confirm the managers response in writing
- if no satisfactory response is received within a reasonable timescale, then she should seek advice from her union representative

At this stage the UNISON steward may well realise this is not an isolated issue and is in fact a trust-wide or locality-wide issue for district nurses. In that case a meeting should be called, irrespective of which union they are in. Management may well provide a temporary response and promise a better long term solution. Either way, it will be essential to confirm that what Laura is required to do, can be done safely, and if necessary less essential work must be suspended. An agreed written statement setting this out is essential.

An individual member of staff, having taken advice and sought support, should:

- talk to colleagues, their union steward and where appropriate their professional body to clarify their concerns and identify if other colleagues have similar concerns
- take a careful note of their own concerns in writing
- put their concerns in writing to management either individually or collectively with colleagues. Explain your concerns simply and clearly and where possible support them with evidence and references. The pro forma letter in Appendix 2 of this handbook is a guide to what should be said
- insist that any instruction to undertake duties which are believed to be unsafe is put in writing by management, in response to your letter
- bear in mind that even where a manager says that they will "take responsibility"

for any harm that may result from your acts or omissions as a result of your concerns, this is meaningless. You (and they) cannot delegate your duty of care

If these steps do not result in your concerns being addressed, then it is essential you take further advice from your union steward and/or Regional Officer.

At this stage it is not inevitable that a formal grievance is lodged. The purpose of the letter may be to highlight concerns and have a detailed discussion.

Individual members of staff, or groups of staff, should not feel awkward or embarrassed about insisting on safe practice, or safe working conditions for themselves. The days are gone when it is acceptable for a Trust Board to counterpose the interests of staff to those of patients in such circumstances.

Staff and their trade unions should aim to be seen as effective guardians of safe and high quality services. If we are able to halt or amend proposals to demoralise staff, or skill mix staff, inappropriately cut services or provide potentially unsafe services, then we will be better placed to secure better working conditions, better working practices, more satisfying jobs and greater security of employment. In turn, that will help staff recruitment and retention.

Failure to highlight concerns does no one any favours - patients, staff or ultimately the trust.

10.4. What is the appropriate collective response to these conflicts?

There are several steps to consider:

Step One. Identify the problem and seek to clarify precisely what management are saying about it. Seek that clarification in writing.

Step two. Set out the issues and the case for colleagues and management. Be clear what outcomes staff are seeking

Step Three. Test member support. This can be done informally in a department, ward or health centre, or more formally through a meeting. Is it possible to take the issue forward as a collective issue ? Make sure everyone is clear about the link between individual accountability and collective action.

Step four. What is the timescale? Is it an urgent problem or an ongoing one (or both)

- or is it a new service or a delivery change? If there is immediate risk to patients or staff, or management intend to implement changes immediately, then it will be essential to warn of a formal grievance to trigger the status quo clause in the grievance procedure, or alert health and safety representatives.

Step five. Is it possible to work with management in partnership or will a more formal approach, insisting on consultation rights and the grievance procedure be necessary? If the latter, then be sure the case is clear when you make it a campaign issue.

Step six. At all stages ensure all members are involved, that stewards are centrally involved and that the Regional Officer's advice and support is sought.

Many of these issues can be resolved informally or in partnership with management. If this approach can be followed, take it. It is likely to be the most productive. Use the arrangements for Working in Partnership which now exist nationally to insist on union involvement. If the trust won't take note of reasonable concerns then more formal means will have to be used, using the grievance procedure, building a collective response and if necessary a public campaign.

One thing is clear. The sorts of concerns about safe practice that this handbook has discussed **must** be addressed where they exist. If some employers are so foolish as to not want to do so, then staff must ensure these concerns are tackled.

How UNISON supports individual members of staff with concerns will be a local judgement for stewards, branches and Regional Officers. Where matters can be resolved informally they should be. Where a formal response seems appropriate, it is crucial that no one launches precipitate action without taking advice. It is essential that the Regional Officer be alerted well before any whistleblowing, in particular, takes place to advise and protect staff considering doing so.

Example: Mental health services at risk

Staff employed by the local NHS Trust become increasingly concerned that the level and range of community mental health services are falling well short of what all professions consider to be the bare minimum. This problem is the culmination of four years' budget

deficits. There is enormous pressure on clinical psychologists, community psychiatric nurses, therapists, administrative and other staff, made much worse by a decision to freeze all vacancies until the end of the financial year.

The Trust Trade Union staff side committee has raised the matter at the last meeting of the Joint Consultative Committee but were told by the Chief Executive that regretfully the Board have decided the freeze must stay in place and might even extend beyond the end of the financial year. There is pressure from staff to take things further, especially after two staff are threatened by patients who are frustrated at the long waits to see staff.

Issues. The staff side should obtain the minutes of the Trust Board meeting and seek a written explanation from the Trust as to the reason for the staff freeze and what the Board think are the implications for safe practice.

The staff side unions should urgently test staff opinion. They should organise meetings in each of the main workplaces, preceded by a newsletter explaining their concerns. They should consider a quick members' survey to discover the impact of the freeze on patient care and staff safety. They should ask all staff to immediately start recording all instances where patient care or staff safety is compromised and give guidance on how such instances should be recorded. All such instances should be contrasted with the National Service Frameworks, policy documents, standards and local protocols.

If the meetings support the stand taken by the Staff Side Committee then there is a mandate to raise the matter publicly. They have already met with the Chief Executive, but it would be worth asking to address the full Board meeting. That would be an opportunity for a staff lobby and press publicity - and possibly to get the Board to reconsider its decision.

The Staff side should contact local patients' organisations, other health professionals, Councillors, MPs and the local media. Full time trade unions officials should be involved. A professional Briefing should be prepared explaining the concerns, but being careful not to identify, even indirectly, any individual patients. The Briefing should set out clearly what practical steps staff are seeking (eg extra staff, different priorities).

Any attempt to single out staff highlighting concerns should meet with a robust response from the Staff side, involving full time officials if necessary.

10.5. Using rights to information, consultation, training and facilities

Representatives of recognised trade unions have a number of legal rights and NHS policies to draw on in insisting they be properly consulted on the issues highlighted in the handbook.

These legal rights, which should be improved upon within a local recognition and facilities agreement, include, for union representatives:

- the right to disclosure of information for collective bargaining purposes - which would certainly include staffing levels, for example
- the right to be consulted, in good time, and with a view to reaching agreement on avoiding or reducing any redundancies which may be threatened
- the right to be consulted on any transfer of employment arising from a merger, de-merger, reorganisation, sale of business or contracting out of work
- the right to elect health and safety representatives and numerous rights for them to exercise their rights to inspect, sit on a safety committee and be consulted on health and safety matters
- the right to elect learning representatives to influence, for example, training
- the right to paid time off for trade union duties - including on precisely the sort of issues raised in this handbook
- the right to paid time off for training as a trade union representative
- the right to have certain facilities in the workplace - noticeboards, filing cabinet and, increasingly in the NHS, the use of a computer, email and telephone for reasonable purposes
- the right to not be victimised or treated less favourably because of their trade union role

Members have a right to reasonable time off (without pay unless agreed with management) to attend trade union meetings

10.6. NHS policies

In addition in England, Scotland, Wales and Northern Ireland there exist various Human Resources policies, which set out additional rights for trade union representatives, often enhancing these legal rights.

Across the UK there are Partnership Agreements which seek to give staff and trade unions greater involvement in service development, so that staff are involved from the start of changes, not only when proposals have reached an advanced stage.

Local recognition and facilities agreements further set out what these rights are in any particular employer.

UNISON encourages local stewards to get involved at the earliest possible stage using these avenues so that the issues outlined in the handbook can be raised as constructively and effectively as possible.

Collecting the evidence

It is essential that staff, individually and collectively, are able to demonstrate what their concerns are. To do this it is essential to keep records of the concerns - the impact on patient care, or on staff.

Clinical records should support any claims. Such records must:

- be in writing, be legible, dated and signed
- be amended by crossing out, not by tippex
- be concise, relevant, accurate and factual

Other evidence can include:

- standards staff are expected to meet with details of how and why they cannot (eg waiting times),

- protocols, policies, National Service Frameworks, or Health Improvement Programmes that risk being breached (how, when, why and who by)
- equipment and facilities that are inadequate, unsafe, broken or not available
- staff shortages or inappropriate delegation setting out why this is the case and the consequences
- staff surveys
- the results of risk assessments

Summary

There is a real positive side to the changes in the NHS. Unprecedented resources are going into the NHS and, in theory at least, there is a new culture of partnership with staff. This should mean recognised unions having a much better chance to influence changes in service delivery and priorities locally.

11. Influencing Health Service "modernisation"

Much of this handbook has explained the framework of contract of employment, statute, case law and professional accountability. The purpose has been to give health service staff more confidence in challenging unsafe and inappropriate practice, which may harm patients or staff, including influencing the "modernisation" of services.

We should be prepared to embrace change where it meets the criteria set out in this handbook and where the pay, terms and conditions of our members are not adversely affected or improved as appropriate. We want improved services. We know that many services fall below the standards we want to provide. If there is genuine open consultation, and unions are involved from the start of changes being considered, then we should get genuinely involved and influence what changes develop.

You may find the following checklist useful in doing that:

- Where significant changes are proposed to service delivery or service provision, has all relevant information been provided to staff and their trade union(s)?
- Have the detailed proposals and supporting evidence been provided sufficiently early to enable staff to be meaningfully consulted or has the crucial decision already been taken?
- Does this include precisely what is proposed, why, when, who is affected

and how and what the claimed impact on patient services will be?

- Has advice been sought from trade union(s), professional bodies, other Trusts and departments?
- Have staff emphasised there must first be clarity on the process - timescale, status of proposal, nature of consultation and staff involvement?
- Are staff and management clear about the obligation to consult properly with staff and their trade union(s)?
- Are local trade unions clear about the advantages of partnership and the new ways of working this may involve - including the willingness to embrace change as long as it meets the criteria set out in this handbook?
- Have local stewards networked via UNISON with other trusts where similar proposals have been made or introduced?

Ambulance staffs and response times

Mike is an ambulance service control room manager. He has become increasingly unhappy at pressures to improve statistics for response times by crews. The Chief Executive, regarded as a bully, has made it clear that the current position where the trust is near the bottom of the "league table" for response times is unacceptable. He says he wil hold line managers responsible if they don't improve and has warned crews they need to "sharpen up their act". Response times improve, but do so primarily because responses times start being logged from the moment the crew are alerted not from when the call is first received. Some crews are also recorded as having arrived when they are almost there, not when they actually do. Mike, along with other crews and some managers objects to this. but is worried about raising his concerns.

Issue. This type of situation exists in several services, not just the ambulance service. At the least Mike - and other colleagues - should record their concerns with their line manager. If the concerns are widespread and seem well founded, then UNISON should consider raising the matter formally but in a way that does not highlight Mike as the lead complainant. If the practices continue then this is just the sort of incident where it may be appropriate to involve the local MP, the CHI or its equivalent.

The following checklist may be useful in taking the first steps to ensure safe working where there are immediate or ongoing staff concerns

APPENDIX I
A checklist for safe services

If there are immediate and urgent concerns

- ☐ Has the reason for those concerns been set down in writing with supporting evidence by the staff affected?
- ☐ Have appropriate protocols, Codes of Professional Practice, Trust policies and clinical evidence been referred to in the written statement of staff concerns?
- ☐ Does the statement of concerns from staff ask management to set out in writing their response - and if the problem is due to management action, to set out a clear explanation of what has happened and why?
- ☐ If it is appropriate, has a risk assessment been carried out covering the risks to patients as well as those to staff?
- ☐ Have those written concerns with supporting evidence been given to relevant managers and professional leads?
- ☐ Are all staff who are in any way affected, aware of the issues through a union newsletter and briefings?
- ☐ If there has been a response from the trust, is the process and timescale of any discussion clear and in writing?
- ☐ If the matter cannot be resolved informally, is management aware a grievance may be pursued?
- ☐ If there is no reply, or an unsatisfactory response, has advice been taken on whether the issue should be formally

pursued through a grievance - and if so are the members clear what outcome they are seeking?

- Do the members feel adequately supported by local union representatives and where appropriate regional officials? Has anyone asked any non-members if they'd like to join the union?
- If the issue is eventually resolved are the details confirmed in writing?

2. If there are longer standing concerns

- Has evidence been collected to demonstrate why staff are concerned?
- Is the evidence supported by reference to appropriate protocols, Codes of Professional Conduct, Trust policies, health and safety policies and clinical evidence where relevant?
- Are the risks to patients highlighted as well as those to staff?
- As well as individual statements of concern has an attempt been made to determine the scale of the problem and who else may be affected? Has there been a staff meeting, a newsletter or a survey?
- If management have agreed to discuss the concerns, is everyone clear on the process and timescale to be followed to tackle the concerns?

These letters and others are available on the UNISON web site www.unison.org.uk/healthcare/dutyofcare where they may be downloaded and amended. Other pro forma letters are also available there.

APPENDIX 2
Pro-forma letters raising concerns

1. Letter raising concerns about the impact of an ongoing lack of resources

Date

Dear (Manager)

Staffing levels in (service, department, health centre)

This letter seeks to draw your attention to concerns relating to the impact of the current /proposed level of staffing in our (service, department, health centre).

The concerns arise from the following facts, which have been carefully recorded:

1.

2.

(List the key issues in a factual manner, possibly referring to additional evidence in an appendix. Where possible give dates, statistics, references, including from your Code of Professional Conduct, Trust policies, national policies or standards)

As a result of this staffing situation, this letter is to formally record the following concerns about the impact on the standard/range of services which can be provided, and upon our own ability to maintain reliable records and work safely. We also have concerns about the potential (actual) impact of this situation upon the personal health of the staff affected. These concerns are specifically:

1.

2.

As a result I/we would appreciate an early meeting to consider how this situation can be addressed in a manner that enables us to work safely in everyone's interest. I would appreciate a written response to this letter, preferably in advance of that meeting.

Finally can I draw your attention to the relevant sections of our Code of Professional Conduct/Trust policy, which I believe is relevant?

Yours sincerely

2. Letter raising concerns about a proposal to change the service provision or delivery - for an individual or a department or team

Date

Dear (manager)

Changes to service delivery/ provision (give name of service etc)

This letter seeks to draw your attention to concerns arising from changes to the service/how our service is provided. The concerns are both about how the changes are being consulted on or introduced, and about the actual proposals themselves:

1.

2.

(List the key issues in a factual way, possibly referring to additional evidence in an appendix. If the concerns are that there is insufficient consultation, or negotiation, refer to the trust's own policies.)

As a result of these concerns I/we would appreciate receiving the following as soon as possible:

1. Written details of the precise proposals, their status and the timescale for introducing them

2. Details of the evidence that these proposals are an improvement on the present service and of the consideration given so far to issues arising from the trust's duty of care to patients and staff. In particular could you clarify what consideration has been given to patient safety and safe working practices in respect of (list any specific concerns)?

3. Written details of the proposals for consultation and working in partnership with recognised trade unions on the introduction of these proposals

4. An assurance that no further steps will be taken to progress this proposal until there has been appropriate consultation with staff and their union representatives on all aspects of these proposals including the implications for safe practice.

Your early reply, and an early meeting to discuss these issues, is requested.

Yours sincerely

Cc.

3. Letter from a sympathetic manager drawing attention to concerns raised with him/her

Date

Dear

Concerns regarding (name them)

I write to draw your attention to concerns which have been raised within my department/unit/locality/ward regarding (name the issue).

The issues were first raised with me by (name) on (date). I them met with (names) on (date) to clarify precisely what the concerns were and to see how best they could be addressed.

I attach my note of that meeting and the original letter from staff/UNISON. I also attach my initial response, which seeks to address some of the concerns but also promises to respond further on the outstanding issues.

I am concerned that the outstanding matters raise issues, which impinge on the duty of care which the trust and I have to staff/patients. In particular I would draw your attention to:

1.

2.

(Summarise issues of concern)

Each of these raises issues relating both to departmental policies which we may be close to breaching, and to the Code of Professional Conduct for (name occupation), in particular Clause (number) which states (include extract from the Code).

The staff in the department/unit/ward/locality, whilst appreciative of the fact that I have met with them and listened to their concerns, have made it plain that they intend to pursue these matters until the risks they identify are removed. Moreover as a registered professional (state profession), I believe I may personally be at risk of being in breach of my own Code of Professional Conduct.

I would appreciate an early meeting with you to discuss these matters in order that we may tackle these matters together now rather than await a potential grievance and a continuing risk.

Yours sincerely

Enc (attached documents)

All NHS managers in England are expected to observe The Code of Conduct for NHS Managers. (30) The Code also applies to all private sector managers managing staff or services for the NHS or managing units primarily providing services to the NHS. For senior managers (board members or the level immediately below) the Code is part or their contract of employment. A similar Code exists for Wales. At the time of writing it is expected that similar arrangements will be made for Scotland, and Northern Ireland.

The following are extracts from the Code, which is available in full at www.unison.org.uk/healthcare/dutyofcare

APPENDIX 3 Extracts from the Code of Conduct for NHS Managers

Code of Conduct for NHS Managers

1. "NHS manager(s)…will observe the following principles

- make the care and safety of patients my first concern and act to protect them from risk
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies
- be honest and act with integrity
- accept responsibility for my own work and the proper performance of the people I manage

and

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of public and patients
- be guided by the interests of patients while ensuring a safe working environment"

and

- ensure that the public are properly informed and are able to influence services

2. "I will also seek to ensure that NHS staff are

- valued as colleagues
- properly informed about the management of the NHS
- given appropriate opportunities to take part in decision making
- given all reasonable protection from harassment and bullying
- provided with a safe working environment
- helped to maintain and improve their knowledge and skills and achieve their potential
- helped to achieve a reasonable balance between their working and personal lives"

3. I will also seek to ensure that:

- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear"

Implementing the Code

" NHS Managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason
- given clear achievable targets
- judged consistently and fairly through appraisal
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives

APPENDIX 4
References

1. *Recruitment and retention: A public service workforce for the 21st century.* Audit Commission 2002

2. *The effectiveness of health care teams in the National Health Service.* Aston University 2002. Professor M. West et al. See also: *The impact of People Management on Business Performance.* The Institute of Personnel and Development.

3. The Human Resources strategies for England, Scotland, Wales and Northern Ireland are regularly updated. www.unison.org/healthcare has links to the current documents

4. The Modernisation Agency in England has a constantly updated database of developments at www.modernnhs.nhs.uk

5. For example in *Pathology - the essential service* P.4. DoH 2002.

6. *The National Racial Harassment Survey 2000*, Lemos and Crane 2002. Commissioned by the DoH in 2000, but unpublished. It showed that 47% of black and ethnic minority staff in the NHS had experienced harassment at work. *Improving the health of the NHS Workforce,* Nuffield Trust 1998, also commissioned by the NHS, reported an epidemic of stress and poor mental health amongst NHS staff, particularly linked to heavy workloads.

7. *Health and safety in acute hospitals in England* National Audit Office 1996 was sharply critical of health and safety arrangement and led to a raft of new policies by the DoH.

8. *Section 1, Employment Rights Act* 1996
9. Johnstone v Bloomsbury Health Authority 1991 1CR 269
10. Walker v Northumberland County Council 1995 1All ER 737
11. See (1) Reed and (2) Bull Information Systems Ltd v Stedman 1999 1RLR 299 on sexual harassment, and Weathersfield v Sargent 1999 IRLR 94 on instructions to racially discriminate
12. Bolam v Friern Barnet Hospital Management Committee 1957, 2 All ER 118
13. Bolam. op cit.
14. See Generic Working in the NHS. UNISON. 1995.
15. Wilsher v Essex Health Authority CA 1988 1 All ER 871
16. Deacon v McVicar 7.1.1984 QBD.
17. *Code of Conduct for NHS Managers*. Doll 2002
18. *Speaking out without fear*. UNISON, is a useful summary of the law and good practice.
19. *Learning from Bristol: The Report of the Public Inquiry into Children's heart Surgery at the Bristol Royal Infirmary.* 1984-1995 DoH.
20. *Report of the NHS Taskforce on Staff Involvement* DoH 1999. See also the Scottish Executive Partnership web site and the Stewart Rouse report 2002
21. See, for example, the case of nursing sister Angela Knott who won £414,335 damages at the High Court in October 2002 as a result of Newham NHS Trust failing to provide safe arrangements for lifting patients because of poor staffing levels and only one hoist being available between two wards. Angela Knott had to leave her job due to the resulting back injury.
22. *Improving the health of the NHS workforce* Nuffield Trust. op cit.
23. *The Positively Diverse 2000 Survey* Lemos and Crane. DoH 2000 showed similar results
24. *A First Class Service: Quality in the new NHS* , DoH 1998, similarly defined in Quality Care and Clinical Excellence (Welsh Office 1998)
25. *The Essence of Care - patient focussed benchmarking for health care practitioners,* DoH 2001 available from DoH PO Box 777 London SE1 6XH
26. *Code of Practice on Disciplining and Grievance Procedures*. Advisory Conciliation and Arbitration Service.
27. M. West et al. op cit.
28. *Reg 1. Management of Health and Safety at Work Regulations,* 1992.
29. Section 8.3 *Nursing and Midwifery Code of Professional Conduct* 2002.
30. *Code of Conduct for NHS managers*. op cit.

APPENDIX 5 Further information

UNISON has numerous resources available to support members wishing to act on the issues raised by this Handbook.

If you are not yet a member and wish to find out about the benefits of membership please **phone UNISON*direct*** on 0845 355 0845. Alternatively, you can download a membership form from www.unison.org.uk/join. Some of the benefits to health service members can be found on our web site.

Stewards and branch officers exist in every NHS employer and can give support or direct you to where you can get support

Regional Officials exist across the UK and are available to give specialist advice and support to stewards and where appropriate, to members.

The UNISON web site
http://www.unison.org.uk is the most comprehensive of any trade union. It contains the complete text of this handbook and links to related documents, as well as letters that can be downloaded and adapted for local use.

UNISON publications cover many of the issues in the handbook in more detail. Many of them are available for download from the union's website.

Of particular interest may be:

- The Law and You - a UNISON Guide to Key Employment Rights
- Stress at Work - a guide for safety reps
- Harassment - a UNISON guide
- Violence at work - a guide to risk prevention
- An unhealthy attitude - sickness absence control measures
- Ending back pain from lifting
- Health and safety reps pack

- The administration of medicines
- Generic working in the NHS
- Risk assessment - A UNISON guide
- A negotiator's guide to the working time regulations

Employer's web sites can very useful. There are direct links to them from the UNISON web site.

Professional organisations and statutory bodies all have their own web sites. They can also be accessed via the UNISON web site.

Price £5.00

(Free to UNISON members)

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