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WHAT DOES THE BABY P STORY TEACH US ABOUT STAFF ENGAGEMENT, AVOIDING CONFLICT, REDUCING RISKS AND SAVING MONEY?
What is conflict?
What do we mean by a whistleblower?
What behaviours constitute negative behaviours?
Why do clinicians end up in distress, and on sick leave?
How can we help clinicians return to their clinical teams?
Why do other members of the team stay silent?
What are the impacts upon services of a poor listening culture
What are the costs, personal, professional and to the organisation?
Every child matters 2003
For most parents, our children are everything to us: our hopes, our ambitions, our future. Our children are cherished and loved. But sadly, some children are not so fortunate. Some children’s lives are different. Dreadfully different. Instead of the joy, warmth and security of normal family life, these children’s lives are filled with risk, fear, and danger: and from what most of us would regard as the worst possible source – from the people closest to them. Victoria Climbié was one of those children. At the hands of those entrusted with her care she suffered appallingly and eventually died.
What is a whistleblower?

- A worker who raises a concern about wrongdoing at work. Also called "raising a concern"

A worker can report things that aren’t right, are illegal or if anyone at work are neglecting their duties, including if health and safety of an individual is in danger, damage to the environment, a criminal offence, the organisation isn’t obeying the law, or covering up wrongdoing.

Source Patients First submission to Speaking up review. 2014
Parallels to Mid Staffs failures.

- Mid Staffs Public Inquiry
- The board failed to prioritise patient safety over financial targets

- Haringey Children’s services
- GOSH Board failed to prioritise patient safety over financial targets?
• Haringey management referral
  • Is Kim ill?
  • Request to reduce her sessions
  • Service cannot reduce her sessions as we are short of paediatricians.

Occ Health
• She is fit.
• Workload is the concern
• Reduce her PAs in dialogue with her
• Recurrence of stress is likely to be due to heavy workload.
Organisational context for bullying behaviours

Definition of bullying;

A person is bullied or harassed when he or she is repeatedly subjected to negative acts in a situation where the victim finds it difficult to defend him or herself.

Einarsen

Bullying and harassment at work; epidemiological and psychosocial aspects Bergen. University of Bergen 1996

Theory has moved away from blaming individuals but to understanding the personal, social and organisational dimensions that interact to lead to bullying acts, and the impact upon individuals.
Organisational factors that correlate with workplace bullying

- Workloads- people are more tired, and mistakes happen.
- Role ambiguity; uncertainty about specific job roles – eg how much authority do we have?
- Role conflict eg where role requirements violate moral values, or needs & aspirations lead to behaviours unacceptable to ones colleagues- middle management?
What would we see in the workplace?

- Whispering campaigns - attempts to discredit.
- Undermining decisions taken
- Exclusion from meetings
- Taking away previous responsibilities
- Increasing workloads
- Taking away support.
- Labelling someone as mad or a troublemaker.
Negative acts  Einarsen

- Withholding information from people
- Being deprived of responsibility for work tasks
- Gossip or rumour
- Social exclusion from co-workers or work group activities
- Hints or signals from others that you should quit your job
- Devaluing your work or efforts
- Neglect of your opinion or views
In view of the turnover that she reports in this department it might be reasonable to review other paediatricians job plans and see whether there is not an overload on all members of this highly specialised and responsible section of the hospital, Occupational health physician 22nd February 2007
A doctor accused of failing to spot that Baby Peter was suffering abuse days before his death is "suicidal" and unfit to appear before a disciplinary hearing, the General Medical Council has heard.

A paediatrician accused of failing to spot Baby Peter’s snapped spine two days before he died is “suicidal” and has left the UK, a medical hearing was told.
What can we learn from this case study

- Clinicians raising concerns together are likely to have a really serious concern.
- Trust the experienced doctor to understand risk.
- Everyone has a limit to how much work they can do safely.
- Most patient safety issues are system issues. Eg notes missing.
- Blame culture; we turn on the individual rather than look at the organisational factors and context.
- Recruit the right people
- Support your staff in speaking up
How to prevent workplace bullying

- Create an atmosphere of mutual respect.
- Use opportunities to speak about negative behaviours, and how this can impact upon people and make the services unsafe.
- Show by example that you do not resort to threats.
- Demonstrate your tolerance of difference.
- Diversity strengthens teams.
- Be objective about complaints.
- Are procedures being used fairly?
Organisational costs of case study

- Experienced staff left the service.
- The service was clinically unsafe.
- An under qualified locum was left holding the fort.
- Money was spent on paying a consultant who was very experienced to stay away.
- Money spent on lawyers £80,000 in house.
- Money spent on investigations and inquiries Hundreds of thousands.
- Reputational damage.
- Most importantly lack of any real learning for the service and fear in other staff who saw what happened.
what happened?


Team has just won team of the month excellence award.

I have become a campaigner, and founded Patients First network.

Health Select Committee has now recognised that the treatment of whistleblowers has been a “stain on the reputation of the NHS”.

Jeremy Hunt has moved to ban gagging clauses.
Francis review awaited.