Understanding employee whistleblowing in health care

Summary of the research

Recent Inquiries and reports into poor standards of NHS care have highlighted the vital role that employee whistleblowing can play in the detection and prevention of harm to patients. Since the 1998 Public Interest Disclosure Act all NHS trusts have been required to establish formal policies and procedures for promoting and enabling whistleblowing and these legal duties are now enshrined in the NHS Constitution. In spite of this, recent hospital scandals, most notably at Mid Staffordshire, and numerous surveys of NHS staff have shown that many healthcare professionals working in the NHS feel inhibited in raising concerns about poor quality care, with many believing that even if they did raise concerns their organisation would fail to act or would respond inappropriately. It is clear that in the post-Francis era of 'openness, transparency and candour' whistleblowing policies remain central but are inadequate, with many staff reluctant to raise concerns for fear of bullying, intimidation or reprisals by managers and colleagues. The purpose of the proposed study is to review the theory and empirical evidence on whistleblowing, drawing on material from a variety of different disciplines, sectors and countries with the aim of identifying theoretically grounded and evidence-informed lessons for the design and implementation of employee whistleblowing policies in the NHS.

The specific objectives of the literature review and scoping study are to:

1. Explore the main strands of the academic and grey literature on whistleblowing and related concepts such as employee silence and to identify the key theoretical and conceptual frameworks which inform the understanding of employee whistleblowing.
2. Synthesise empirical evidence from different industries, sectors and countries with regard to the organisational processes, systems, incentives and cultures that serve to facilitate (or impede) employees raising legitimate concerns.
3. Examine the legal framework for whistleblowing in relation to health care as a mechanism for promoting (or inhibiting patient safety) and review the approaches to whistleblowing in relation to EU member states and consider what lessons can be learnt at domestic level from such comparisons
4. Distil the lessons for whistleblowing policies and practice from the findings of formal Inquiries into serious failings in NHS care.
5. Ascertain the views, expectations and experiences of a range of key stakeholders, including service user and carer representatives, about the development of effective whistleblowing policies in the NHS.
6. On the basis of findings relating to points 1 to 5, to develop theoretically-grounded and evidence-informed practical guidance for policy makers, managers and others with responsibility for implementing effective whistleblowing policies in the NHS.

Overall, the study will contribute enhanced understanding in support of NHS systems to encourage and support staff to raise legitimate concerns. Findings will be disseminated through a national seminar held in London, professional and trade journals, social media including blogs and twitter, and through service user groups, patient charities, HealthWatch and organisations such as the NHS Confederation. Key insights will also inform the development of learning sets for the national NHS Leadership programmes run by HSMC in collaboration with the Manchester Business School and KPMG.

Background and rationale

Whistleblowing – the disclosure, either to a person in authority or in public, of information concerning unsafe, unethical or illegal practices – is central to current debates about addressing poor standards of care in the NHS. Since the 1998 Public Interest Disclosure Act, all NHS trusts have been required to have policy and procedures in place for dealing with whistleblowing. This is now enshrined in the NHS Constitution, which mandates "an expectation that NHS staff will raise concerns about safety, malpractice or wrong-doing … as early as possible". Yet, a recent House of Commons Health Select Committee report on patient safety concluded: "the NHS remains largely unsupportive of

whistleblowing, with many staff fearful of going outside official channels to bring unsafe care to light". Indeed, the Francis Inquiry noted that at Mid Staffordshire there had been a number of whistleblowing policies in place that had "the clear objective to empower employees to raise concerns and to ensure that those concerns, where valid, were acted upon". The Inquiry heard, however, that despite the existence of such policies, no adequate support was given to staff who attempted to raise concerns, with witnesses describing "an endemic culture of bullying" with graphic examples of victimisation of those who did raise concerns (Francis, 2013). Francis concluded that the culture at the Trust militated against health professionals openly raising concerns for a number of reasons: they considered that such concerns would not be acted on effectively, or they feared negative repercussions from colleagues and/or victimisation by management. Yet despite these serious concerns about the effectiveness of current whistleblowing polices we still lack a firm evidence base to guide change. Against this background then, there is an urgent need to distil the theory and evidence on whistleblowing from other sectors and countries with the aim of helping to shape whistleblowing polices in the NHS.

As an indication of the urgency of this task, in July 2014 (between the first and second submission of this proposal) the government announced that there would be an independent review into whistleblowing - *Freedom to Speak Up* - to be chaired by Sir Robert Francis QC, The report published in February 2015, identified 20 Principles and associated Actions which should underpin whistleblowing polices in the NHS and recommended that the Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions.

This report provides further data and insights to that already published that will be folded into our own work. A key distinction between this new Francis report and our own proposals is that our work will be rooted in the organisational and cultural practices and processes of healthcare, as it is the enactment of good intentions, embedded in organisational realities, that poses most problems. Our study will thus build on and expand the *Freedom to Speak Up* report, using the Principles and Actions outlined in the report as prompts in our own stakeholder interviews.

Why research is needed now

The NHS Constitution identifies three key expectations relating to whistleblowing:

- that staff should raise concerns at the earliest opportunity;
- that NHS organisations should support staff by ensuring their concerns are fully investigated and that there is someone independent, outside of their team, who can provide support;
- that there is an existing legal right for staff to raise concerns about safety, malpractice or other wrongdoing without suffering any detriment.

In addition, NHS Employers and national regulators and professional bodies, including, the Royal College of General Practitioners and the UK Nursing and Midwifery Council have produced guidance for doctors and nurses, midwives and students who wish to raise concerns about quality and safety. Although whistleblowing has therefore been mandated and promoted by employers, regulators and professional associations, numerous surveys across different professional groups working in the NHS confirm significant shortcomings (or, at least, perceptions of significant shortcomings) in the protection and support offered to whistleblowers seeking to raise legitimate concerns about poor patient care. A possible reason for this is the widely held perception among health professionals that they will be victimised, ostracised or bullied if they raise concerns about colleagues or poor standards of care (NHS Staff Survey, 2012; MPS, 2012). This is not a new development. Over a decade ago, the report following the Bristol Royal Infirmary Inquiry recognised that many staff, particularly junior staff remained silent in the face of poor care or wrongdoing as they were fearful of raising concerns and/or challenging superiors because of the possible repercussions: "There is a real fear among staff (particularly among junior doctors and nurses) that to comment on colleagues, particularly consultants, is to endanger their future work prospects. The junior needs a reference and a recommendation; nurses want to keep their jobs. This is a powerful motive for keeping quiet" (Kennedy Report, 2001). It is to these organisational and cultural constraints that our work is oriented.

These concerns remain current. The 2012 NHS staff survey found that, although the majority of NHS staff (90%) would know how to report any concerns they might have, only 72% reported that they would "feel safe raising these concerns" and only just over half (55%) reported that they would "feel confident"

that their organisation would address them (NHS Staff Survey, 2012). Moreover, in 2013 the Royal College of Nursing polled its members and almost a quarter (24%) said they had been warned off or discouraged from whistleblowing, and 45% said that their employer took no action even when they had spoken out. Similarly, a survey of doctors undertaken in 2012 by the Medical Protection Society (MPS) reported that only 11% of respondents said they would be confident of the process if they blew the whistle, and 49% of doctors reported that "fear of consequences" is why the whistleblowing process is ineffective. Only a third (33%) of doctors who had blown the whistle said that colleagues supported their decision, and less than 40% felt that their concerns had been addressed (with 18% feeling isolated as a result, 14% moving location/jobs and 12% reporting health issues as a consequence; MPS, 2012).

Of course, not all forms of whistleblowing are motivated by genuine concerns about patient care and some may arise from staff grievances or even be of a malicious nature. Indeed, within the literature whistleblowers are often portrayed as either courageous employees who act to maintain standards or malcontents who pursue their own interests regardless of the dysfunctional consequences for employees and organisations (Jones and Kelly, 2014). Distinguishing between whether someone is a 'hero' or 'troublemaker' for raising concerns (or, sometimes, ambiguously both) is often difficult in complex and dynamic health care contexts. Indeed, local discursive practices (e.g. on the nature of success, failure, risk and performance) and operational contingencies (resource constraints, service rivalries, stakeholder pressures etc.) are likely to have a powerful shaping role here. Whistleblowing happens in a deeply (organisational) cultural and highly situated context. Thus whistleblowing policies need very careful design, implementation and enacting.

Against this background it is clear that there are problems in relation to current whistleblowing policies in the NHS, and that there is an opportunity to learn from the experience and evidence from other sectors and countries. The proposed literature review and scoping work seeks to do this, and to develop-evidence informed guidance to assist NHS managers and others responsible for designing effective whistleblowing policies. It will build on our own closely related research covering:

- Theoretical and empirical work exploring the antecedents and consequences of whistleblowing in health care and other sectors and countries (Blenkinsopp et al., several).
- Theoretical and empirical work exploring the relationship between health care cultures, health care quality and patient safety (Mannion, Davies et al., many).
- Ongoing empirical work exploring the relationship between hospital board oversight of patient safety, including new national quantitative analysis showing that there is an association between hospital trust board governance/competencies and the willingness of staff to raise concerns about health care quality and patient safety (Mannion et al 2014; Millar et al, 2013).
- Literature reviews and evidence syntheses on organisational factors and performance in health care (Mannion, Powell, Davies et al., many). See the list of references for related publications by the research team.

Unpacking Whistleblowing

Whistleblowing has emerged over recent decades as a distinct field of academic enquiry with researchers exploring a range of inter-related issues, including the social and psychological processes underpinning whistleblowing decisions (Gundlach, Douglas & Martinko, 2003; Miceli & Near, 2005); the personal characteristics of whistleblowers (Bjørkelo, Einarsen, & Matthiesen, 2010); the organisational factors which serve to enable or inhibit whistleblowing (Kaptein, 2011; King, 1999); the impact of reporting wrongdoing on whistleblowers themselves (Alford, 2001); national cultural differences in attitudes and responses to whistleblowing (Park, Blenkinsopp, Oktem & Omurgonulsen, 2008), and the role of emotion in the decisions over whether or not to blow the whistle (Henik, 2008; Blenkinsopp & Edwards, 2008).

Over recent years the field has become more embedded in the broader literature relating to *employee voice* (and *silence*), and in that exploring the nature and antecedents of *pro-social behaviour* within organisations (e.g. Burke & Cooper, 2013). This reflects a recognition that the academic literature has traditionally focused on a dichotomous choice between whistleblowing and silence – that is when faced with wrongdoing an employee makes a conscious choice either to remain silent or to act by raising concerns (Teo and Casperz, 2011). Yet, and as highlighted by Jones and Kelly (2014), this simplistic dichotomy obscures a range of alternatives strategies to whistleblowing which may be just as effective in identifying and preventing wrongdoing. Such strategies might include interpersonal approaches such

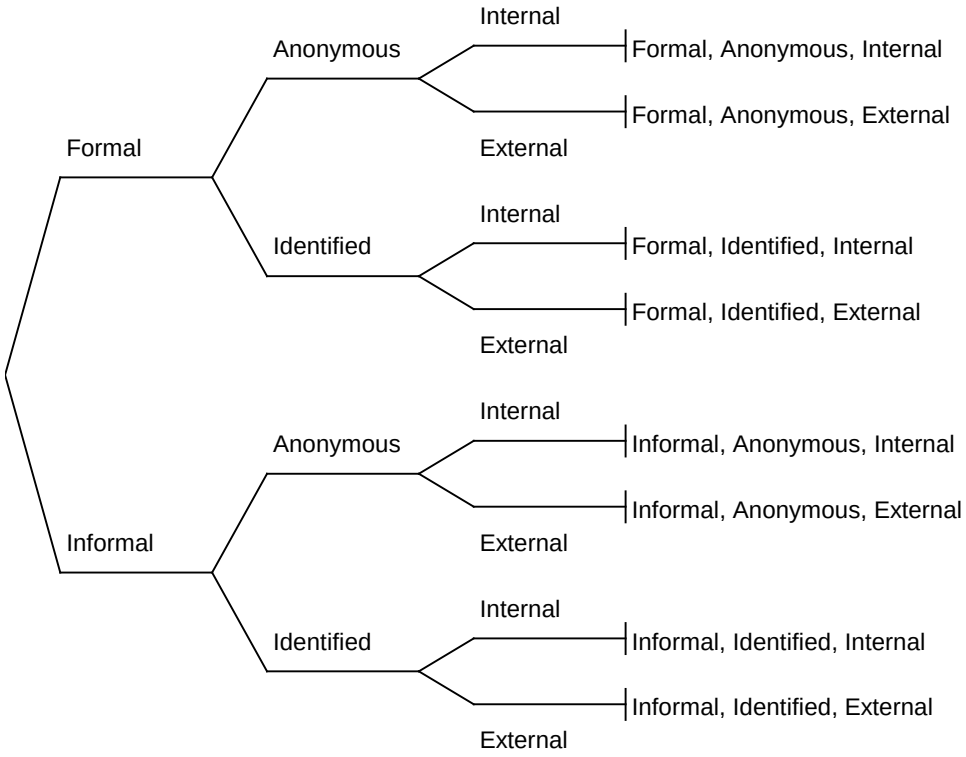
as the use of humour, or sarcasm to signal discontent, or informal and off-the-record discussions with managers and employees.

Blenkinsopp and Edwards (2008) note that before coming to any decision on whether to blow the whistle employees usually find themselves trying to work out exactly what is happening, often through engaging in dialogue with colleagues and seeking a 'second opinion'. Blenkinsopp and Edwards (2008) frame this kind of behaviour as a prelude to whistleblowing, and as Jones and Kelly (2014) suggest these 'informal and circumlocutory' channels of communication may be valuable organisational mechanisms for addressing poor standards of care. Indeed, they argue that they can prove more effective than formal reporting systems, as they are more likely to circumvent the 'deaf effect', a term originally coined by Keil and Robey (2001) to describe the reluctance of senior managers to hear and accept 'bad' news. These topics are now studied widely within management and organisation studies, for example the analogous concept of 'collective myopia' (Chikudate, 2002), and in particular though the study of organisational responses to employee voice (Burke & Cooper, 2013).

There has, however, been very little application of these theories and concepts to explore and understand strategies, structures and cultures in health care organisations. In the context of the proposed research Mowbray et al (2014) argue that research on pro-social voice has tended to focus on the behaviour of individuals and ignored the longstanding work on employee voice found in the industrial relations/human resource management literature, which examines the wider organisational mechanisms for promoting staff opinions and employee participation in decision-making' (Lavelle et al, 2010: 396). The concerns expressed by Francis (2013) and earlier Inquiries in the NHS such as Bristol (Kennedy, 2001) highlight the importance of understanding both individual mechanisms for raising concerns and the wider organisational systems which can enable or constrain open discussion and effective organisational responses to poor care (Davies and Mannion, 2013).

A useful framework for understanding the different routes for whistleblowing has been developed by Park, Blenkinsopp, Oktem & Omurgonulsen (2008), who suggest that individuals are faced with a number of choices in relation to raising concerns with regard to whether to report internally or externally, formally or informally, and anonymously or on the record (see Figure 1). This framework will be used as one of the approaches to structuring the documentary analysis.

Figure 1: A Typology of Whistleblowing



Study aims and objectives

The overall aim of the study is to review the theory and empirical evidence on whistleblowing, drawing on material from a variety of different disciplines, sectors and countries, in order to identify lessons for the design and implementation of employee whistleblowing policies in the NHS. The specific objectives are to:

1. Explore the main strands of the literature on whistleblowing and related concepts such as 'employee silence' and the 'deaf effect' - where organisations are reluctant to respond to concerns (for example in business and management, organisation studies, public administration, sociology, industrial psychology, philosophy, law and health services research), and to identify the key disciplinary sources of ideas, paradigms and theoretical and conceptual frameworks that inform the understanding of employee whistleblowing.
2. Synthesise empirical evidence from different industries, sectors and countries with regard to the organisational processes, systems, incentives and cultures that serve to facilitate (or impede) employees raising legitimate concerns. In particular the organisational factors associated with employees remaining silent when confronted with wrongdoing and why, and in what ways, organisations may be unresponsive (or even hostile) when employees seek to raise concerns.
3. Examine the UK legal framework for whistleblowing in relation to health care as a mechanism for promoting patient safety and healthcare quality, including the legal implications of introducing a "duty of candour" in health care practice; compare and contrast the approaches to whistleblowing in health care in relation to other EU member states as well as other countries, and consider what lessons can be learnt at domestic level from such comparisons.
4. Distil the lessons for whistleblowing policy and practice from the findings of formal inquiries into serious failings in NHS care. In particular, explore the organisational (cultural and processual) reasons why some staff fail to raise concerns about failings in the quality of care and why health care organisations fail to respond appropriately when they are made aware of such concerns.
5. Ascertain the views, expectations and experiences of a range of key stakeholders, including representatives of service users about the development of effective whistleblowing policies in the NHS, and explore perceptions of how the latest Francis whistleblowing report and current reforms and organisational incentives are impacting on the motivations of employees to raise concerns and the willingness of NHS organisations to respond when they do so.
6. On the basis of findings relating to points 1 to 5, develop theoretically-grounded and evidence-informed practical guidance for policy makers, managers and others with responsibility for

implementing effective whistleblowing policies in the NHS. A secondary outcome of the work will be to provide recommendations for the methodological design of future empirical research into the organisational dynamics and impacts of whistleblowing.

Research design

The study design combines four Work Packages (WPs) including a systematic narrative review, analysis of the legal framework for whistleblowing, in-depth analysis of formal Inquiry reports, and interviews with key stakeholders and front-line staff.

WP1: Narrative review (lead John Blenkinsopp) (months 1-12)

The literature review focuses on Objectives 1,and 2 and aims to to explore the main strands of the literature relating to whistleblowing and to identify the key disciplinary sources of ideas, paradigms and theoretical and conceptual frameworks which inform the understanding of employee whistleblowing in health care contexts. Systematic reviews are an established means of summarising available research. A number of approaches are available (Table 1), and selection depends on the review's aims and the nature of the evidence to be explored (Popay et al, 2006). We do not propose to evaluate evidence from studies in the manner of a Cochrane Review. There are two reasons for this. First, the whistleblowing literature is very diffuse, indeed some of the relevant literature may not even be labelled as whistleblowing (e.g. research on incident reporting, employee voice and silence). Though there may be valuable insights to be gained from these diverse sources, it would be difficult to achieve a synthesis of the research. Second, there are very few studies which gather evidence specifically related to whistleblowing. The topic is very sensitive, and whistleblowers who agreed to participate in research could put themselves at risk of retaliation, professional body sanctions or even prosecution. To avoid these problems researchers have typically explored participants' responses to hypothetical scenarios. Such studies can clearly be evaluated in terms of the rigour of their research design, and the findings offer important insights to practitioners and policymakers, but it would be difficult to utilise the kind of weighting of the evidence required for a traditional systematic review.

We therefore propose to undertake a narrative systematic review, covering:

- Theories and frameworks for understanding whistleblowing, organisational and employee silence and related concepts in business and management, organisation studies, public administration, sociology, industrial psychology, philosophy, law and health services research.
- Empirical evidence from other sectors and countries regarding the implementation of, perceptions of, and impact of whistleblowing policies.

To ensure rigor, we will follow sophisticated contemporary strategies in searching for and mapping evidence in complex multi-disciplinary areas (Greenhalgh et al, 2005). Prior work by the applicants has seen related reviews and empirical syntheses published in top journals (e.g. Scott et al 2003a,b; Jung et al, 2009; Millar et al 2013). Literature searches will be carried out using both natural language and thesaurus searching (where available).

Our search strategy will involve four stages. First, we will search using keywords such as whistle blowing, whistleblowing, employee voice, employee silence. We will use standard bibliographic databases such as Philosopher's Index, PhilPapers, Medline, Cinahl, Helmis, ABI-Inform (Abstracted Business Information), PsychInfo, and Web of Knowledge, HAPI (Health and Psychosocial Instruments Database) and Health & Safety Sciences Abstracts., as well as Google Scholar and OpenSIGLE which provide coverage of the grey literature. Second, we will develop inclusion and exclusion criteria based on factors such as the focus of the work (e.g. papers on organisational citizenship behaviour often mention voice and whistleblowing, but only in passing and would thus be excluded). After initial searching we will then examine the reference lists of relevant papers to help identify additional material (snowball search). This will also enable us to improve the specificity and precision of our database search strategy. Third, we will assess the relevance of the outputs, looking first to exclude work that is clearly unrelated (e.g. US research on the use of payments to those who

blow the whistle on tax evasion), indirectly relevant (e.g. incident reporting systems in high risk industries) and directly relevant (i.e. work on whistleblowing in healthcare systems). We will also identify and search by key authors and carry out citation searches from key references. All bibliographies of papers selected for inclusion in the final review will also be examined for further relevant citations. Fourth, we will seek to classify the work into theoretical, empirical and policy categories, while recognising the potential for overlap between them. The bibliography thus developed will be circulated to international experts within the field (e.g. members of the International Whistleblowing Research Network, of which the team are members) for comment, specifically to assess whether there are any other related and more up to date sources the research team should seek to include. to identify and fill any gaps in our formal literature search, and to identify new databases and search terms if required.

Once we have a comprehensive bibliography we can begin to analyse the literature. In the absence of prior reviews of the whistleblowing field it is difficult to assess what form of research synthesis will be possible. In the systematic literature review methodologies typically used within management and organisation studies (e.g. Tranfield, Denyer & Smart, 2003) narrative review (rather than meta-analysis) is the most common approach to research synthesis, and we will most likely undertake a narrative review. However, collating all relevant research may demonstrate greater integration and cohesion within the field than we presently assume, in which case a meta-synthesis approach may be possible.

Table 1: Summary of alternative approaches to systematic review
(adapted from Popay et al, 2006 p89)

Review approach	Unit of analysis	Focus of observation	End product	Area of application
Meta-Analysis	Programme	Effect sizes	Relative power of similar programmes	Whole programme application
Narrative Review	Programme	Holistic comparison	Recipes for success	Whole or majority replication
Realist Synthesis	Mechanisms	Mixed fortunes of programmes in different settings	Theory to determine best application	Application of appropriate mechanisms

This work package (WP1) aims to produce a synthesis that embrace the complexities and ambiguities associated with developing an understanding of whistleblowing in the context of care services, and to identify the different narratives and contours of debate in an inclusive and holistic manner. The review will be oriented to identify the different understandings and theories of whistleblowing, to explain these, and to examine their relevance to contemporary healthcare in a way that is accessible to a non-academic audience

Blenkinsopp will liaise closely with the Principal Investigator (Mannion) and the other researchers throughout the review process to ensure insights can be shared and the findings integrated with the other work packages. For example, the review of conceptions and theories of whistleblowing will inform the analysis of Inquiry reports and the content of stakeholder interviews with frontline staff. In return, the scoping of stakeholder/frontline perspectives will provide contemporary ways of thinking about whistleblowing in healthcare that could usefully be examined critically in the review of conceptions and theories. A meeting to present preliminary findings and discuss relationships between them will be held early in the process to facilitate this exchange, and meetings between the review leads and the other work package leads will be arranged as necessary.

WP2: Analysis of national and international legal frameworks for whistleblowing (lead Jean McHale) (months 1-9)
This part of the project focuses on Objective 3 and will examine the legal frameworks for whistleblowing in relation to health care in the United Kingdom as a mechanism for promoting or for inhibiting patient safety. It will consider the interactions between the protections given to employer-employee confidentiality, patient-professional confidentiality, and public policy questions supporting disclosure of information. The analysis will examine the impact of the Public Interest Disclosure Act 1998 upon whistleblowing practices in healthcare in general, and upon patient safety in particular. Moreover, it will consider the interface between the statutory framework for whistleblowing and health care professional regulatory structures concerning patient confidentiality and duties to disclose information where in the public interest to do so. In doing so, a key goal will be to consider the potential implications of a new "duty of candour" in health care practice.

The analysis here will compare and contrast approaches to whistleblowing in health care across EU member states. This is particularly important given the increasing interest in developments at EU level to facilitate patient safety. The EU is particularly concerned with such issues in the light of the practical consequences of enhanced patient mobility across Europe through patients accessing their free movement rights (ECJ, Case C-372/04 *R (on the application of Watts)* v. *Bedford Primary Care Trust, Secretary of State for Health* [2006] *ECR* I-4325) and the development of the EU Patient Rights Directive (Directive 2011/24/EU of the European Parliament and of the Council of 9th March 2011 on the application of patients' rights in cross-border healthcare).

Whistleblowing across the EU will be examined in relation to three groups: those with "strong" protection (the UK and Luxembourg); "medium" protection (Germany and France); and "weaker" protection (Greece and Spain). The project will consider what lessons can be learnt at domestic level from such comparisons, and more generally in relation to the development of a coherent policy in relation to patient safety at EU level in the future. The implications in relation to professional practice requirements and patient rights will also be explored. Further comparisons will be drawn with the developments at federal and state level in the USA and in relation to contemporary arrangements in Canada, Australia and New Zealand.

The approach will comprise a review of the primary legal sources e.g. legislation and case-law across each of the jurisdictions being studied, alongside relevant government publications, parliamentary records (such as Hansard), Codes of Practice and guidance documents. The goal of the analysis will be to ascertain how the legal framework are conceived in theory and implemented in practice, noting major areas of agreement and divergence.

WP3: Documentary analysis of formal Inquiry Reports (lead Martin Powell) (months 1-9)
The documentary analysis of formal Inquiry Reports focuses on Objective 4 and will distil the lessons for whistleblowing policies and practice from the findings of formal Inquiries into serious failings in NHS care. We will review the findings and recommendations relating to whistleblowing by formal Inquiries or key government-commissioned reports into patient safety and poor standards of care in the NHS. Inquiries/reports reviewed will include both Mid Staffs reports, the latest Francis review of whistelblowing policies in the NHS, the Keogh and Berwick reviews, and the Ayling, Neale, Shipman and Bristol Inquiry reports. In addition, we will review the responses of the main stakeholders to these reports. For example, for the 2013 Francis Report, these would include the government's initial and final responses; the Health Select Committee; NHS organisations such as the NHS Confederation; and 'producer' organisations such as the Royal College of Nursing.

For each report, we will gather information on issues such as: who was the whistleblower; how and why did they 'blow the whistle'; what factors did or could facilitate or inhibit the action; and what were the consequences for the whistleblower? The method is based on a (historian's) 'reading' of the documents (cf Powell, 1994), which will be backed by thematic coding in a deductive and inductive sense. Electronic searches of the documents will be performed using keywords from the conceptual/ theoretical work, and arising inductively from the documents. This will produce a comprehensive account of employee whistleblowing from the major NHS documents over a period of time which will set out an analysis of whistleblowing (who; how; why; with what effect to NHS and individual?), along with findings and recommendations from the reports. This will enable a focus on the factors that facilitate and inhibit

whistleblowing; and the degree of policy learning over time. For example, how did any relevant recommendations from (say) the Bristol Inquiry impact on subsequent whistleblowing policies?

WP4: *Key informant interviews with policy advisers /user reps (lead Ross Millar) (months1-9)*
This work package addresses Objective 5. We will interview key policy advisors, commentators, employee organisations, trade unions, Royal Colleges and representatives of user and carer groups (c. 15). The aim here will be to explore current high-level perceptions and preoccupations about whistleblowing policies in the post-Francis era and to explore views about the feasibility of implementing the 20 Principles and associated Actions arising from the 2015 *Freedom to Speak Up* report.

Integrating the findings from the different elements of the study

All WPS will be fully integrated and inform each other. This will be facilitated by regular face to face (also via Skype) meetings =f the whole research team to discuss the implications of emergent findings. The findings from the key informant interviews will be used to help guide the literature review and ensure that particular issues raised by key stakeholders with regard to implementation of the Principles and Actions associated with the Freedom to Speak Up report are covered in the review. The advisory board meetings will also allow external input into integrating and meshing the findings from the different elements of the study.

Strengths of the research team and contribution of each member

The applicants between them have considerable experience of undertaking literature and evidence syntheses and managing complex research projects funded by NIHR and other funders. Crucial to the success is the collective experience of conducting organisational research and collaborative work with patients, practitioners and policy makers.

Professor Mannion (University of Birmingham) has led many NIHR and PRP funded research projects. He has an international reputation for his research on health care cultures, quality and patient safety. His work in these areas was used as evidence at the Mid-Staffs Public Inquiry. As PI for the study he will take full responsibility for managing the project and provide overall academic direction and leadership. He will be an active participant in all key aspects of the research and ensure integration across the various strands of study. He will devote (0.25 WTE) of his time over 12 months

Professor Blenknsopp (University of Hull) has experience of researching whistleblowing in health care and other sectors. He will take responsibility for leading the narrative review (0.15 WTE) over 12 months and supervise the researcher recruited to assist the review (0.5 WT) over 12 months.

Professor Powell (University of Birmingham) has considerable experience of health policy analysis and has led several NIHR and PRP funded research projects. He will take responsibility for undertaking the analysis of the Inquiry reports and will contribute 0.2 WTE of his time over 9 months,

Dr Millar (University of Birmingham) is a leading qualitative researcher who has worked on several NIHR and PRP funded projects. He will undertake the stakeholder interviews as well as take the lead in obtaining national and local ethical/governance clearance for the study. He will contribute 0.1 of his time over 9 months.

Professor McHale is the Director of the Centre for Health Law, Science, and Policy at the University of Birmingham. She is the author of several text books on health care law and has an international reputation for her work in health care, including work on whistleblowing policies. She will review the legal basis of whistleblowing in the NHS and distil the lessons from EU countries, contributing 0.2 of her time over 9 months.

Professor Davies (University of St Andrews) has an international reputation for his work on knowledge mobilisation and health care quality. He will provide help in interpreting the findings and participate in knowledge mobilisation and project dissemination and contribute 8 days in total to the study.

Dissemination and expected outputs

The proposed study aims to fill important gaps in our understanding of the antecedents and consequences of whistleblowing in health care contexts. All the lead applicants are skilled communicators and are embedded in wide range of service user, professional and academic networks suitable for disseminating and mobilising the findings. It is envisaged that the proposed research will generate and disseminate knowledge products or outputs in six main categories. These are:

• The main report submitted to the NIHR, which will provide intelligence for enhanced whistleblowing policies in the NHS. This will be founded on an analysis of the strengths, weaknesses and gaps in existing theories about whistleblowing in terms of their application to healthcare, and on insights for the NHS from empirical evidence drawn from other sectors and countries.

• A set of PowerPoint slides presenting the main findings from the research made available for widespread use.

• A practical guide drawing out the main managerial implications of the research. This will be made available to NHS managers and clinicians with responsibility for implementing whistleblowing policies. HSMC has a number of outlets for facilitating the dissemination of findings, including a quarterly electronic newsletter directed at NHS managers and clinicians across the NHS.

• A seminar in London for key NHS stakeholders, including patient representatives to listen to, discuss and debate the research findings. This seminar will provide an opportunity for participants to relate the study findings to their own experiences and contexts, and will help to promote distribution and use of the practical guide.

• Presentations at two externally organised conferences, one targeted at academics and one at practitioners, for wider dissemination of the theoretical and practical findings of the study. The most suitable academic conference would be the European Health Management Association conference, an acknowledged international meeting point for researchers, teachers, managers and policy-makers with an interest in healthcare. The most suitable practitioner conference would probably be that staged by the NHS Confederation for a general audience of NHS senior managers.

We will further disseminate our recommendations and guidance through professional and trade journals, social media including blogs and twitter, and through service user groups, patient charities, Healthwatch and through management organisations such as the NHS Confederation.

A key outcome of the study will be to provide theoretical and evidence informed recommendations for the design of future empirical research into whistleblowing in the NHS and we will seek to disseminate the guidance through various managerial and professional networks. Russell Mannion, Martin Powell and Ross Millar will feed the findings into the curriculum and learning outcomes of teaching programmes run by HSMC, including the NHS Leadership programmes run jointly by HSMC, Manchester Business School and KPMG.

Plan of investigation

There is considerable overlap between the work packages (parallel working) to allow a large volume of work to be completed within the 12 month period. Nonetheless the points of intersection between the work packages – where emergent findings from one can and should influence the detailed design of another – have been carefully considered. To expedite progress we plan on starting work on ethical and governance approval in the period after formal approval of project funding but before the official start-date. We will also use this pre-start period to assemble the project advisory board and begin the regular timetable of group meetings. Timetabled activities have been carefully set to allow timely production of draft briefing documents (to facilitate cross-team communication of interim findings), crafting of plain language summaries and NHS briefing materials (for dissemination activities), and the production of standard academic outputs.

Project management

The applicants between them have considerable experience of large and complex research projects funded by NIHR and other funders, and of conducting collaborative research with patients, carers, practitioners, managers and policy makers. As PI for the study, Mannion will take full responsibility for managing the project and will provide overall academic direction and leadership. He will be an active

participant in all aspects of the research, overseeing, and coordinating the various strands of work and participating in the analysis, and ensuring integration across the various strands of study.

All the researchers will be in regular contact throughout the 12 month period. As most are based at the University of Birmingham we will have frequent face to face meetings. Three specific meetings are planned for the whole project team to bring together interim findings and consolidate the inter-linkages between the work packages. The first of these will occur in approximately month 4 (substantial group meetings have already taken place in the preparation of the application), and will focus on the emergent findings from the literature review work and the key informant interviews. The second will occur in approximately month 6 and will provide a chance to discuss methodological challenges and knowledge engagement strategies. The third planned meeting for the whole team will take place around month 10 and will be aimed at operationalizing a clear knowledge exchange programme, finalising outputs and capitalising on overarching outputs. Alongside these larger-scale face-to-face interactions, multiple bilateral and small-group interactions will be encouraged and facilitated, making full use of modern tools such as Google Groups.

Project advisory group

An early task will be to select and invite members of a project advisory group. This group (approximately 8-10 people) will be balanced between patient, carer and public representatives, senior managers and experts from external regulatory agencies (e.g. the CQC). In most of these cases, early conversations have indicated a willingness to participate. The main role of the advisory group will be advice on overall project direction, interpretation of emergent finding in the light of patient and service realities, and identification of knowledge exchange avenues.

Approval by ethics committee

The key informant interviews may require ethical and governance clearance in order to proceed. It is intended to commence this process as soon as possible following formal confirmation of research funding by NIHR. This will allow some progress to be made before the formal project start. As a team we have considerable experience in gaining ethics approval from NHS LREC and MREC bodies and negotiating access to a range of NHS organisations. We would also gain ethical approval from the University of Birmingham Research Ethics Committee. The time taken to negotiate access and gain ethical approval has been incorporated into the proposed timetable.

Patient and public involvement

Patient involvement is central to this bid as we are seeking to boost understanding of the role that whistleblowing can play in the detection and prevention of harm to patients and in particular the organisational and legal processes that appear to support (or hinder) employees to raise legitimate concerns about poor quality care. The application has been discussed from its early development with Pam Alonzo (previously a part-time PPI engagement officer for CLAHRC West Midlands) and Malcolm Bowcock (who has recently retired from the NHS, with considerable experience as a clinical governance lead, and who is now engaged in patient involvement activities for the same CLAHRC). Both Pam and Malcolm will sit on the project advisory committee and will be involved in discussions about the design of the key informant interviews as well as aiding the interpretation of the results from the literature and documentary reviews from a patient/public perspective. Peter Walsh, CEO, Action against Medical Accidents **(**AvMA) - the UK charity for patient safety and justice - has also agreed to join the project advisory board. We will also seek to involve representatives of Health Watch and the Patients' Association. Further, we will gather the views and perspectives of representatives of patient and carer groups as part of the key informant interviews. In line with INVOLVE's guidance we have incorporated the cost of payments within the budget to accommodate the fees paid to two service users (noted above) to attend the advisory group meetings, at the rate of £150 per person per meeting, in addition to the costs associated with any travel and subsistence costs incurred.

Justification for costs and value for money

The research team have been selected for their specialist knowledge in the specific area of the project they will be responsible for. The fact that they have carried out similar studies in cognate areas in the past will ensure that intellectual synergies are maximised and costs are used efficiently. Due

consideration has been given to the varying degree of input co-applicants will have at various project stages and staff costings reflect this, allowing sufficient time for individuals' work to be completed whilst providing best value to the NIHR. The project aims to generate maximum value for money by ensuring that the actionability of results is embedded at the heart of the research, minimising risk of research insights and outputs not being put into action due to too narrow an audience/research-base.

On a practical level, all expenditure has been calculated in order to minimise costs and promote value for money. For example, where possible journeys will take place at non-peak times; accommodation has only been costed where strictly necessary and only for team members who live too far away to make a same-day return journey; consideration has also been given to whether subsistence is required on a full- or half- day basis. Resources have been carefully allocated across the relevant work packages to ensure sufficient capacity for the work envisaged, alongside central resources to enable project coordination and synergy across the work packages. Major costs requested are salary costs associated with the literature work, field work, data analysis, and study integration. We have aimed for a mix of (named) senior staff input and researcher support (to be recruited) justified on the basis of the complexity and ambition of the proposed study. We believe the costs requested are commensurate with the scale and ambition of the proposed work, and the range and likely influence of the proposed project outputs.