Lucy Letby and the Reporting of Unethical Behaviour in the NHS

The case of Lucy Letby represents another failure to act on concerns raised by NHS staff about the actions of their colleagues. Though the Letby case is undoubtedly extraordinary and extreme, it follows a pattern which is depressingly common within the NHS. This is important to understand – the eternally politicised position of the NHS in the public imagination means every case risks being interpreted as an example of current government policy going wrong. But the basic pattern of problems arising, staff raising concerns and then being either ignored or treated as the problem, has been described in the reports of every public inquiry into NHS failings since at least the 1960s.

The various ways in which employees attempt to raise concerns about problems within an organisation is collectively termed “voice”. For complex healthcare organisations such as the NHS voice often involves crossing boundaries of expertise and perspective, most obviously when clinical staff voice their concerns to managers. Both politicians and journalists are tempted by the argument that this is the problem, and opine that an NHS ‘run by doctors and nurses’ would always put the patient first rather than worrying about organisational reputation, resources or their own careers. Yet for decades now the NHS has seen a trend of more clinical staff moving into senior management roles – a 2017 survey of NHS board members showed half of the executives and a quarter of non-executives came from a clinical background. As of 2018, twenty two percent of all managers in the NHS were medically trained. At the time of the Letby murders the Chief Executive at the Countess of Chester Hospital was a nurse. While research does suggest that NHS trusts with a larger proportion of doctors sitting on their boards perform better in terms of a range of quality outcomes, there is no direct evidence supporting how clinician presence among NHS senior management improves how they respond to concerns raised by staff.

Voice can act as an early prevention system, but sufficient evidence needs to have been collated to warrant suspicion and investigation by organisational managers. The early stages of investigating unethical behaviour need to be carried out covertly and sensitively, given at this point there may be no proof of wrongdoing. Managers are often wary of acting on anecdotal evidence about such sensitive issues given the embarrassment and bad feeling that result amongst people being accused of things for which there is no proof. Changing culture to ensure that the voice of employees is heard and supported must be a priority. Achieving this would require the NHS to ensure it has enough managers in post so that sufficient resource is devoted to this important activity, while the current regulatory model which can foster a blame culture, lead to burnout, and a higher-than-normal CEO turnover, must be considered as well.

Criticism of decisions made by senior leaders at the Countess of Chester Hospital by medical consultants, highlights that clinicians and non-clinicians have different perspectives on organisational priorities which led to the scale of the Letby situation. At the December 2016 board meeting, the hospital management were concerned about the reputational damage which would result from the neo-natal fatalities should news of the investigation be shared externally, not least if the concerns turn out to be unfounded. On the other hand, the consultants, who are bound by ethical, legal and moral codes of conduct, instead prioritised their focus on the number of fatalities. In the case of Lucy Letby, it was the yearly average number of fatalities being reached halfway through the year that alerted consultants to the

problem in the first place. However, despite a small initial investigation in June 2015 identifying that Letby had been on shift for all three fatalities it was deemed not suspicious at that point by managers. More time elapsed, as the neo-natal unit manager had to wait 56 days for a meeting with the Chief Nurse to discuss their concern about Letby as a common factor in the deaths. It is not clear whether, at that early stage, managers did indeed not consider the situation to be suspicious, or whether they were already considering the reputational risk of an investigation into something yet unproven. It is also possible that hospital managers, looking at a wider range of metrics than neo-natal deaths did not consider the implication of that figure at that early point in time. On the other hand, the consultants whose main priority is to preserve life, were highly focused on this figure and placed great importance on it, not taking into account the other wider organisational variables being considered by the hospital management. These different perspectives highlight the need for organisations to be very clear on the nature of the data they need to identify problems early on, and to take into account that organisational performance metrics may not be the most important ones.

We believe there are important lessons that must be be learned from the Letby case. Analysing key events using a 'time-based perspective' enables us to problematise dilemmas regarding voice about unethical behaviour in NHS organisations, including for example, to develop awareness of unethical issues, support the timely enactment of voice, and encourage managerial action in response to voice. Key questions for NHS Senior managers should include: how long does it take someone in your organisation to decide to voice a concern? How does someone decide that it is the right time to voice? And how long does it take for a manager to act once a concern is known? As such, we suggest NHS organisations who wish to be proactive in the identification and prevention of unethical behaviour must consider:

1) how it takes time for voices inside the organisation to generate evidence for unethical behaviour,
2) how perceptions about such behaviour might evolve and change over time as new data, or different sources of evidence, emerge, and;
3) to acknowledge that it is often most difficult to voice concerns at the time when it is needed most, as supporting evidence and political will for action can be at its lowest.

To find out more about the time-based perspective to identify and prevent unethical behaviour, you can check the authors *recent publication in the Journal of Business Ethics*

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