LEADING AND SPEAKING UP

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Ten years ago, the Francis Report[1] was published following the public inquiry into the failings and hundreds of patient deaths over a number of years at the Mid Staffordshire Hospital. And yet as the Lucy Letby case recently demonstrated, unexpected deaths of vulnerable patients are still occurring and concerns that are raised by staff continue to be ignored.

On a personal level if we had concerns about the care of one of our family members or a close friend, we would do everything in our power to our raise concerns and to persist until something improved. So why as a healthcare professional is it so hard to speak up and to effect change?

And we know that it is still hard to do so because the data from the annual NHS Staff Survey[2] shows that.

Introduction

In this blog I'll look at speaking up in the NHS post the Francis report and the actions that were taken then and the current state of speaking up in NHS. I'll explore the consequences of not speaking up.

I'll then highlight what role leadership plays in enabling staff to speak up and what responsibilities leaders have to make change happen.

Speaking Up

What do I mean by speaking up? The phrase covers a number of actions: raising a concern, making a disclosure, making a complaint, whistleblowing, taking out a grievance and suggesting an improvement.

Following the publication of the Francis Report in 2013, the NHS introduced Freedom to Speak Up Guardians in NHS organisations in 2016. Their role is to ensure that staff have a route to be able to speak up about anything that concerns them about working practices, in particular in relation to patient safety. There are now over 1000 Freedom to Speak Up Guardians in NHS Primary and Secondary Care, in independent sector care organisations and national bodies.

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[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Robert Francis QC, 2013

[2] Working together to improve NHS staff experiences | NHS Staff Survey (nhsstaffsurveys.com)

A report by the National Guardian Office in June 2023, Fear and Futility – What does the Staff Survey tell us about Speaking Up in the NHS[3], highlighted that only 61.5% of staff nationally felt safe to speak up and that if they did speak up only 48.7% felt that their concerns would be addressed (a drop in score since 2021).

Staff in organisations in the East of England scored least well on the four Freedom to Speak Up questions compared to NHS staff around the rest of the country.

It is perhaps not surprising that staff experience isn't the same in any organisation and that there are particular groups of staff who feel even more concerned about speaking up. These include staff in different occupational groups, such as staff working in ambulance trusts, midwifery, doctors and dentists and bank staff. And staff with protected characteristics such as ethnicity, gender and long-term health conditions also feel less confident to speak up. There can also be practical difficulties for some groups of staff such as those working on nightshifts.

The Messenger Review [4] set up to examine the state of leadership and management in the health and social care sector stated that "In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report. We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective."

Barriers to Speaking Up

The biggest barrier to speaking up seems to be fear, which manifests itself in different ways. There's fear of not being believed, the fear of being seen as a troublemaker, the fear of damage to personal career prospects, the fear of retaliation or being ostracised.

Paul Whiteing, Chief Executive of the patient safety charity Action Against Medical Accidents said that "There is sadly a long history of whistle-blowers who speak up being ignored, side-lined and blamed, and sometimes forced to pay the price of their efforts with their livelihood". When even senior staff in the NHS raise concerns, as in the Letby case, and they are ignored, how likely is it that staff earlier in their career or in a more junior role will take the risk and speak up?

Consequences of Not Speaking Up

But the consequences of not speaking up can, quite bluntly, be the matter of life or death for patients needing health care.

The Role of Leaders

Leaders have a key role in creating a psychologically safe workplace that gives staff the confidence that if they speak up, they will be listened to, and action will be taken. That's easily said and perhaps harder to do but I suggest that leaders start by talking about patient safety from their own personal

[3] Fear and Futility – Wat does the Staff Survey tell us about Speaking Up in the NHS – National Guardian Office, 2023

[4] Leadership for a collaborative and inclusive future – General Sir Gordon Messenger (The Messenger Review) June 2022

perspective. If a leader expresses their concern about the care their loved ones have experienced or may experience in the future, it enables human connections to be made by sharing concerns and vulnerabilities. And that helps build trust which is the basis of creating psychological safety.

This needs to happen at all levels in an organisation. Staff need to feel that they can trust their immediate line manager to listen and then act. But they also need to hear that same concern for patient safety expressed by the leaders at the top of the organisation and for that to be role modelled at every level in between. Transparency about the outcomes of actions taken to address concerns will also build trust and confidence that it is safe to speak up.

Once staff have spoken up, leaders have a critical role and that is to take every concern seriously. They should use data to assess the concerns that have been raised and to look at trends and patterns. They should be dispassionate about the people involved and not allow personal beliefs that 'someone is too nice' to commit the alleged offences to dominate. Instead, be guided by the data and evidence.

In the trial of the Letby case it was clear that by tracking who was on duty when the babies died that she was the only nurse on duty in every situation. As a non-clinician, confronted with that information, it would have made me at least ask questions and do more investigation.

Using data helps us overcome our unconscious biases. It helps us to focus on the facts, rather than our decisions being swayed by our personal perceptions of the situation. If a data led approach was at the forefront of leaders' minds when concerns are raised and in subsequent investigations, it is likely that patient safety will be improved.

Summary

In summary, all of us that work in health and social care have a responsibility to speak up and raise concerns about any unsafe practice or culture.

In fact, the table of recommendations in the Francis Report starts with a simple statement. "These recommendations require every single person serving patients to contribute to a safer, committed, and compassionate, and caring service."

We must have the courage to put safety concerns we spot above our own personal concerns about the consequences of doing so. But as we have seen there are significant barriers that stop people doing so.

To make it easier to speak up, the primary responsibility lies with anyone in a leadership role to take proactive steps to create a psychologically safe culture, which will in turn lead to the erosion of the barriers stopping staff speaking up. They also need to have the courage to listen with an open mind to the concerns that are raised and search out the data that will provide the evidence or not for the concerns which have been raised. If this doesn't happen, with consistency in every part of the NHS, then sadly, some patients will continue to be at risk of experiencing poor quality care or serious harm.