Written evidence submnitted by Graham Martin, Director of Research, The Healthcare Improvement Studies Institute, University of Cambridge (PSN0001)

1 Questions of interest

The accepted inquiry/review recommendation covered by this submission is number 4 as listed in the Expert Panel evaluation's planning grid, i.e.:

> "Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns."

The submission covers all four of the questions posed by the Expert Panel: has the recommendation been implemented; has there been specific and adequate funding to enable the recommendation to be implemented; has there been a positive impact on patients and people in receipt of care; and was the Government's interpretation and implementation of the recommendation appropriate?

2 The Healthcare Improvement Studies Institute (THIS Institute)

2.1 THIS Institute's goal is to create a world-leading scientific asset for the NHS about how to improve quality and safety in healthcare, hosted by the University of Cambridge. It is guided by a highly participatory, collaborative ethos that combines academic rigour with the real concerns of the people who use and work in the NHS. THIS Institute is supported by the Health Foundation, an independent charity committed to bringing about better health and healthcare for people in the UK.

2.2 Professor Martin is Director of Research at THIS Institute. He was invited by the Expert Panel to submit evidence, and offers this submission on the basis of research he has conducted relating to its foci, and his knowledge of the wider relevant academic literature.

3 Context and evidence

3.1 Problems relating to patient safety and quality of care are not new, and they are not unique to the NHS. They have proved to be persistent, and resistant to interventions to improve them. The failures that occurred and Mid Staffordshire and at Morecambe Bay prompted rightful public outcry and political attention; they also gave rise to a wide range of policy interventions that sought to remedy them. Many of these recommendations related to improving openness and candour in the NHS; that is to say, "the proactive provision of information about performance, negative as well as positive" and "the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested" (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). These features are crucial to the creation of "a culture of safety and learning, in which all staff feel safe to raise concerns," of the kind demanded by the *Freedom to Speak Up* review (Francis 2015).

3.2 There have been some signs of improvement on these fronts in the healthcare system in the ten or more years since the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. But there have also been indications that these improvements have attenuated or reversed. And there have been further major failures in healthcare provider organisations of

the kind that these interventions sought to prevent.

3.3 Improvements include steady advances in indicators relating to openness and candour from the perspectives of staff and patients over time in many organisations. For example, the number of patient safety incidents reported each year in the NHS increased steadily over the 2010s (Illingworth *et al.* 2022) – a trend that is likely to reflect greater awareness of the benefits of incident reporting, greater willingness to report incidents, and less fear of the consequences of doing so (rather than necessarily indicating an increase in the numbers of incidents themselves). Similarly, staff have reported greater confidence in speaking up about concerns about quality and safety (Illingworth *et al.* 2022), and patients in acute hospitals have reported improvements in aspects of care relating to openness of communication (McCarthy *et al.* 2020).

3.4 However, in the early 2020s, these trends have plateaued or in some cases declined. Staff in many parts of the NHS, for example, have indicated that their organisations' responsiveness when issues relating to safety are raised has reduced (Care Quality Commission 2022). Stagnation or decline in these indicators reflects wider falls in ratings of the quality of care in the NHS associated with the Covid-19 pandemic and the backlogs in elective care that have followed it.

3.5 Even without these most recent trends, there are troubling and persistent indications of problems relating to the culture of safety and learning in NHS organisations. Around two fifths of staff state that they would not be confident that they would be treated fairly if they raised concerns about quality or safety (Illingworth *et al.* 2022). Perceptions of community mental health service users of quality, safety and openness have lagged behind those of patients receiving inpatient acute care for some time (Illingworth *et al.* 2022; McCarthy *et al.* 2020).

3.6 The most visible signs that all is not well in the culture of safety and learning in the NHS and social care are the further major failings of safety that have emerged since the publication of the *Freedom to Speak Up Review*, contemporary and historic, including most prominently failures in maternity care at Shrewsbury and Telford, East Kent, and elsewhere. There have also been major failings in the quality and safety of care in inpatient mental health facilities (Liberati *et al.* 2023). In each of these tragic cases, failures of openness appear to have been implicated: the East Kent report, for example, documents at least seven opportunities, based on issues raised by staff or patients, to prevent or limit the harm caused to mothers and babies (Kirkup 2022). These cases are extreme, and constitute huge tragedies for the families involved. But the evidence presented above suggests that the problems of openness that contributed to them are not unique to these organisations. Rather, they are likely to impact all health and care organisations to varying degrees.

4 Evaluation of the policy response to the inquiries and reviews of the 2010s

4.1 A team led by Professor Martin, and funded by the Department of Health and Social Care's Policy Research Programme, undertook an evaluation of various policy interventions that followed the Mid Staffordshire and Morecambe Bay reports, examining their implementation across the NHS (Martin *et al.* 2020).

4.2 The evaluation found mixed evidence of progress towards a culture of safety and learning in the NHS. There was some evidence of improvement in relation to the views and experiences of staff

and of acute inpatients, but evidence of stagnation or decline in the experiences of community mental health service users, for example in relation to the extent to which they felt they were listened to (McCarthy *et al.* 2020). Evidence of innovation and of commitment to improving culture in some organisations was matched by evidence of indifference in others (Martin *et al.* 2023). Organisations in some sectors (e.g. acute care) seemed better prepared to implement policies relating to openness than others (e.g. in mental health services and ambulance trusts). These challenges related in part to the features of these different sectors (e.g. the more hierarchical cultures typically found in ambulance services, which could impede efforts to encourage staff to speak up about concerns), and in part to the nature of the recommendations being made (which were seen by some as being premised on an idealised model of an acute hospital, and were less easy to implement in organisations that were geographically dispersed, culturally and functionally fragmented, and less applicable where care provision was less episodic) (Martin *et al.* 2019).

4.3 One example of this variation is the implementation of the Freedom to Speak Up Guardian role, a central recommendation of the *Freedom to Speak Up Review* and one accepted and actioned by the Government. All organisations were required to nominate a Guardian, but the role came without associated funding and consequently implementation varied greatly. Some Guardians received commendable support and protected time from their organisations; others were expected to incorporate this work on top of existing responsibilities. Guardians' access to senior decision-makers such as boards varies, as does their role in seeking to inculcate culture change and support individuals wishing to speak up (Martin *et al.* 2020, 2023; Jones *et al.* 2021). Thus both the Government's approach to introducing the role and organisations' decisions in implementing it were implicated in inconsistent practice. These inconsistencies are reflected in the levels and kinds of activity reported by Guardians to the National Guardian's Office (National Guardian's Office 2023). While inferences about the direct impact on patients and service users of such variations are difficult, it is likely that such variation is implicated in the divergent cultures of safety and learning documented in the statistics presented above.

4.4 Notably, the policy interventions introduced in the 2010s focused almost exclusively on improving the voice of *staff* about safety and quality, to the neglect of patients (Martin *et al.* 2023). There is increasing evidence of the value and validity of concerns raised by patients and service users about safety, along with increasing availability of such data to the health and care system (Gillespie and Reader 2023). Greater efforts to harvest these insights may pay dividends.

5 Wider empirical research relating to speaking up, safety and learning

5.1 THIS Institute's wider research programme on organisational culture, voice and patient safety provides further evidence relevant to the interests of the Expert Panel in safety culture.

5.2 An important finding of this body of work is that decisions to speak up with a concern about safety are often vexed and challenging ones, not just because of worries about the possible adverse consequences for the speaker, but also because of difficulties in forming and articulating the concern. While more immediate or clear-cut problems may be (relatively) easy to speak up about, concerns relating to more ambiguous issues, where judgements are required about how real and consequential the apparent problem is, are more difficult to raise (Dixon-Woods *et al.* 2022; Martin *et al.* 2018). Issues around colleagues' behaviour, for example, may be particularly hard to speak up about. Yet issues of this kind are often directly and indirectly

related to patient safety: directly in that dismissive, rude, patronising or discriminatory attitudes towards colleagues can suppress voice (Maben *et al.* 2023); and indirectly in that such behaviours may be indicative of other problems of quality and safety (Cooper *et al.* 2019).

5.3 This has important implications for the approach that organisations should take towards nurturing cultures of safety and learning. First, it suggests that there is an important role for Freedom to Speak Up Guardians, and others in similar roles designed to encourage openness, in helping their colleagues to make sense of and articulate their concerns – not just to signpost, report and measure (Martin *et al.* 2021). Second, it points to the importance of focusing efforts to improve voice not just on the 'big ticket' issues covered by 'whistleblowing' and public interest disclosures, but also on much less high-profile acts (Mannion *et al.* 2018). This includes encouraging voice (in various forms, from formal incident reporting to informal raising of concerns) about the range of minor, perhaps even trivial-seeming, issues that may trouble healthcare staff. It also means making efforts to routinise speaking up: making it less of an occasion (with associated high stakes) and more of a taken-for-granted, daily activity (Detert and Burris 2007).

6 Conclusion

6.1 While there is some evidence that cultures of safety and learning in the NHS have improved over the last 10 years, there is also evidence that this progress is stagnating or even reversing. Progress is also unevenly distributed, illustrated not only by egregious examples of organisations that have failed to protect the safety of their patients, but also in persistent patterns of variation between organisations and between sectors (notably mental health).

6.2 In relation to the Expert Panel's questions regarding **implementation** of the recommendations from the *Freedom to Speak Up Review* accepted by the Government, there is evidence of variation in the way this has been interpreted and implemented by individual organisations. This appears to be associated with organisational variation in various indicators relating to safety and openness, such as reporting levels, activities of Guardians reported to the National Guardian's Office, and staff views on the openness of their organisations. The Covid-19 pandemic does appear to have been associated with reduced progress towards cultures of safety and learning, with the views of staff on openness and the experiences of patients showing declines since the pandemic's onset.

6.3 In relation to the Expert Panel's questions relating to **specific and adequate funding** to enable implementation, it is clear that the absence of additional funding for these initiatives has resulted in variations in implementation at organisational level, for example in terms of resourcing of Freedom to Speak Up Guardians. There is also evidence of variations in organisational commitment to and understanding of the aim of advancing a culture of safety and learning. Organisations that have committed more material support to the objectives (for example, in terms of protected time for Guardians) also tend to have committed more symbolic support (for example, in terms of visible leadership of change). The absence of additional funding, and of centrally determined and monitored requirements regarding the level of organisational resourcing needed, are likely to have compromised the success of efforts to foster cultures of safety and learning across the NHS.

6.4 In relation to the Expert Panel's questions regarding positive **impact on patients** and social care

service users, it is difficult to draw any direct inferences about impact on outcomes of care. However, there is evidence that improvements in the experiences of care reported by inpatients are attenuating, and there is evidence that the experiences of community mental health service users have been consistently poorer than those of their acute care counterparts. This may be associated with sectoral differences and/or the feasibility of implementing the recommendations of the *Freedom to Speak Up Review* and others in mental health service organisations. It also suggests that parity of esteem between physical and mental healthcare remains a long way off.

6.5 In relation to the Expert Panel's questions on **the Government's interpretation and implementation** of the recommendation, the Government's interpretation appeared considered and reasonable. Implementation, however, has been affected by the lack of dedicated resourcing, as noted above; this will also have had knock-on effects for other services and activities, from which savings will have been made in order to resource implementation.

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Dec 2023