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1. **Author Introduction**

1.1 I am employed as an academic at Liverpool John Moores University. I have explored effective leadership in the NHS and public sector more broadly for several years, with a recent focus on leadership within Integrated Care Systems and place-based partnerships. The research I draw on in this submission was undertaken in 2023 with Integrated Care System leaders to explore effective leadership in these newly formed structures. Given the significant role Integrated Care Systems play in the NHS, this evidence is intended to support an understanding of how Integrated Care Systems leaders can effectively encourage a culture where staff feel confident raising safety concerns.

1. **How effectively does NHS leadership encourage a culture where staff feel confident raising patient safety concerns, and what more could be done to support this?**

2.2 Key Points

- Healthcare system leaders aim to create a culture underpinned by psychological safety, shared learning, and continuous improvement. However, systemic constraints, notably financial and workforce pressures, significantly challenge the realisation of this aim. Addressing these constraints is important for creating a conducive environment for raising patient safety concerns.

- Recent events and ongoing systemic pressures have underscored the importance of a 'freedom to speak up' culture and the challenges in balancing immediate patient care needs with long-term systemic resilience.

- Clinical and care professionals are pivotal in fostering a culture of shared learning. Greater involvement of these professionals at senior levels within NHS organisations is advocated, alongside expanding partnerships beyond traditional silos to include a broader range of stakeholders. This approach aims to bring new perspectives and resources to improve patient safety.

2.3 Leadership reviews have previously called for a culture change towards more open, inclusive, and supportive leadership practices, with a more compassionate leadership culture prioritising collaboration and open communication (Messenger and Pollard, 2022). The importance of developing leaders who can create environments where staff feel valued, supported, and empowered to raise concerns and contribute ideas has also been noted (Kark and Russell, 2019). Previous research has demonstrated that where leaders and system partners facilitate and support each other to identify learning from successes and failures, this fosters psychological safety and reinforces a shared learning culture (Knight et al., 2024).

2.4 Drawing on my research, the view from Integrated Care System leaders is that they strive to cultivate a culture that prioritises patient safety and empowers staff to raise concerns. This culture is underpinned by psychological safety, shared learning, and continuous improvement. Leaders are keen to take a proactive approach to cultivating this supportive environment; examples include initiatives to bring together clinical leads across various networks to work collaboratively on learning lessons from incidents and issues.

3. System Constraints

3.1 However, leaders are clear about the complex interplay between system constraints and their ambition to foster a supportive culture, noting that broader systemic challenges influence their ability to create a conducive environment for raising patient safety concerns, for example, financial and workforce pressures:

'*A big barrier or a risk to that is the financial position and the real risk that the financial position further exacerbates that manager versus clinician rhetoric.'*

'So, it's not just a statement about promoting quality it's making sure staff have got the right resources to provide the right care because they want to do it anyway…addressing our safety and quality and our workforce issues have got to be hand in hand because you can't do one without the other.'

4. Lucy Letby Trial and Verdict

4.1 Leaders referenced the recent Lucy Letby case as enhancing an acute awareness of the importance of a 'freedom to speak up' culture and the steps to integrate these principles into their organisational ethos[1]:

'*I think that because of the events with the Lucy Letby [trial] lots of people are talking about psychological safety, and the freedom to speak up culture.'*

4.2 Of particular focus was the role of leaders in developing and maintaining a safety culture:

'One of the things we're talking about is the Lucy Letby situation…How do we get our safety, quality agenda and culture because culture is so important in freedom to speak up in an organisation? How do we get that so we're not paying lip service and just coming out with another strategy because of an incident? How do we make it meaningful?'

5. Impact of the Covid-19 Pandemic

5.1 My research findings, supported by the wider literature, demonstrate that NHS provision moved out of the pandemic, which required an immediate crisis response and transitioned to a chronic phase of managing compounded pressures. This confluence of pandemic-induced stress and pre-pandemic systemic issues has led to leaders struggling to balance immediate patient care needs with long-term systemic resilience, potentially impacting safety and quality:

'You compromise quality and safety for the immediacy of the resources.'

5.2 The lasting negative impacts of the pandemic were noted, such as increased elective care waiting lists and backlogs, staff morale and stress levels. Leaders reference the 'exhaustion' and 'challenge' faced by the staff, alongside a surge in vacancy rates, exacerbated by post-pandemic retirements all contributing to gaps and challenges in creating a culture conducive to 'speaking up':

'So, getting through and overcoming that - people were tired, demoralised, and stressed to face what we faced coming out of it. It's just been a perfect storm. I think we've never had anything like this before'.

6. Culture of Challenge and Learning from Failure

6.1 A culture of openness, imperative for ensuring that those involved in healthcare delivery, regardless of their role, can voice concerns regarding quality or safety issues, is more common in organisations where openness is part of the everyday values of the organisation (Martin et al., 2023). My research highlights that leaders who engage in challenging conversations around

[1] NHS England » Verdict in the trial of Lucy Letby

outcomes and delivery facilitate the development of a psychologically safe environment supported by mutual respect among colleagues.

6.2 Within this psychologically safe environment, leaders can engage in open and honest discussion and trust that failure will be seen as a learning opportunity. Importantly, my research demonstrates that this environment is fostered by a sense of shared accountability, which facilitates mutual respect where all opinions are considered of value. Leaders reported that when they engaged in open and honest discussions with others with a focus on demonstrating an acceptance of failure, this developed trust that the response to failure would be supportive and learning-focused:

"You've got to accept things will go wrong, but you're going to be able to support people when that happens, and there's a difference between things going wrong and bad guys".

6.3 In turn, this facilitated the development of a psychologically safe environment:

"We should lead the way in creating a safe, psychologically safe, and supportive culture of continuous learning".

7. <u>Clinical and Care Professional Leadership & Engagement</u>

7.1 Clinical and care professionals play a pivotal role in fostering a culture of shared learning in the NHS; my research supports the move towards greater involvement of care and clinical professionals at senior levels within NHS organisations and systems:

'I think it ought to be a clinically led thing, where we should lead the way in creating a safe, psychologically safe and supportive culture of continuous learning.'

7.2 With leaders expressing their intention to engage clinical leaders:

'Bringing clinical leads of every network, primary care, secondary care, transformation, elective recovery, bringing all of them together, the idea is to start that culture piece to talk about how we create a culture that is about shared learning and psychological safety rather than competition.'

7.3 However, given the move towards integrated systems of working across health and social care, broadening the scope of collaboration to include a wider range of stakeholders could bring new perspectives and resources to the effort to improve patient safety.

8. <u>Summary</u>

8.1 In summary, the need for NHS leadership to actively cultivate an environment that supports staff in raising patient safety concerns necessitates efforts to overcome systemic barriers, prioritise resource allocation, and champion a culture of openness, learning, and collaboration across the health and care system. This should extend beyond traditional silos within healthcare settings, fostering a systemic approach to patient safety and quality improvement.

9. <u>Recommendations</u>

9.1 *Strengthening Clinical and Care Professional Leadership*: Accelerating efforts towards clinical and care leadership and providing more structured support and training for clinical leaders to empower and enable them to lead by example, fostering a culture of safety, openness, and continuous improvement.

9.2 *Resource Allocation and Support:* Resource constraints have a negative impact on staff morale and patient safety. Ensuring adequate resources are available to staff is crucial for enabling them to provide safe care and feel supported in raising concerns.

9.3 *Culture of Challenge:* Encourage leaders who engage openly and honestly with others and demonstrate an acceptance of failure, creating a fertile ground for trust and learning-focused responses.

9.4 *Building Partnerships Beyond the NHS:* Expanding partnerships and collaborative efforts enhance the culture of safety and support. Broadening the scope of collaboration to include a wider range of stakeholders can bring new perspectives and resources to the effort to improve patient safety.

References

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