Written evidence submitted by Roger Kline and Professor Joy Warmington (NHL0074)

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SUMMARY

- Incivility and patient care and safety are intimately linked.
- Black and minoritized ethnic (BME) staff are particularly vulnerable to incivility and discrimination.
- A range of evidence shows BME staff are less likely to raise concerns, less likely to be listened to and more likely to be victimised if they do so
- Research consistently shows two main reasons why people do not raise concerns are, first, a belief that if they do the matter would not be rectified; and second, a fear of retaliation
- NHS boards must develop greater curiosity about the behaviours of staff, and be less concerned with reputation management
- A culture of openness can be cultivated by tackling the fear that makes (BME) staff reluctant to speak up and by being proactive and preventative rather than waiting for individual staff to raise concerns

ABOUT US

1. Roger Kline OBE is Research Fellow at Middlesex University Business School. He authored 'The Snowy White Peaks of the NHS' (2014), designed the Workforce Race Equality Standard (WRES), and was joint national director of the WRES team 2015-17. He gave extensive evidence to the Francis Speaking Up Review and has advised numerous whistleblowers. www.rogerkline.co.uk

2. Prof Joy Warmington is CEO of brap, a charity transforming the way we think and do equality, and visiting professor at Middlesex University Business School. She has held various NHS non-executive positions and been a faculty member of the NHS Leadership Academy. In 2019, she was awarded an MBE for services to healthcare and the community. www.brap.org.uk

3. We believe the failure to hear, listen, and act on the voices of Black and minoritized ethnic NHS staff who raise concerns is a significant risk to patient care and safety, organisational effectiveness, and the health and wellbeing of those staff.

1. CONTEXT

Introduction

4. We understand the focus of this inquiry is on leadership and productivity, as well as patient safety. In our work with NHS organisations[1], it is clear many leaders have a limited understanding of the link between performance, patient safety, and many of the issues raised in the Messenger and Kark reviews, including incivility, respect, and empowering staff to raise concerns.

5. In this submission we summarise why the link between incivility and patient safety should be taken more seriously. We then show that attempts to promote civility and a culture of openness are often hindered because they ignore specific issues facing Black and minoritized ethnic (BME) staff. In doing so our response addresses three questions within the inquiry's terms of reference:

- How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?
- How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?
- How could investigations into whistleblowing complaints be improved?

[1] Between us, Roger and Joy work with over 100 NHS trusts every year.

What is the link between incivility, bullying, and patient safety?

6. Bullying and incivility are a common feature in almost every single independent review of systemic patient harm from Bristol to Francis to Ockenden. Thus, evidence commissioned by Lord Darzi (2008) concluded "*the NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement*."[2]

7. Bullying and incivility impair patient safety for two reasons. Firstly, disrespect in medicine is a threat to patient safety because "it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices."[3]

8. Studies on incivility have concluded that:
   - incivility erodes self-esteem, damages relationships, increases stress, contaminates the work environment, and may escalate into violence[4]
   - rudeness has adverse consequences on the diagnostic and procedural performance[5]
   - incivility has a negative impact on performance. Multiple areas can be impacted including vigilance, diagnosis, communication and patient management (even though participants may not be aware of these effects)[6]

9. Secondly, bullying and incivility undermine inclusion and psychological safety. When either are impaired staff may be less willing to raise concerns or admit mistakes and both adversely impact communication. Research on adverse patient safety events found communication failure was the primary cause for medication errors, delays in treatment, and surgeries at the wrong site and the second leading cause of operative mishaps, postoperative events, and fatal falls.[7]

10. Dixon-Woods et al (2014) noted that:

> *"Managing staff with respect and compassion (is important) since doing so correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and trust financial performance."*[8]

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[2] https://www.ajustnhs.com/wp-content/uploads/2012/09/JCI-Report.pdf
[3] https://pubmed.ncbi.nlm.nih.gov/22622217/
[4] https://www.medscape.com/viewarticle/739328_2?form=fpf
[5] https://pubmed.ncbi.nlm.nih.gov/26260718/
[6] https://qualitysafety.bmj.com/content/28/9/750
[7] https://www.jointcommissionjournal.com/article/S1553-7250(07)33005-5/abstract
[8] https://qualitysafety.bmj.com/content/23/2/106

11. Similarly, Dawson (2014) found that there is "a strong negative correlation between whether staff report harassment, bullying or abuse from other staff in the NHS staff survey and overall patient experience".[9] An environment of bullying and incivility is likely to deter staff from admitting mistakes or raising concerns.

2. BME STAFF AND THE RAISING OF CONCERNS

12. BME staff are less likely than their White colleagues to raise concerns. This is a pressing issue as 25% of NHS staff are now of BME heritage (with the proportion set to rise), including over one third of doctors and one fifth of nurses and midwives.

13. Section 3.3 of the Francis *Freedom to Speak Up Report* (2015) considered the experience of workers from a BME background. At the time, the DHSC said they had initially not requested analysis of the report's survey data by ethnicity as they had no evidence that this was an issue. In fact, when Robert Francis then reviewed the survey data, he found that compared to White respondents the experience of BME staff who raised concerns was very significantly poorer.[10]

Table 1. Comparison of the experience of White and BME staff raising concerns

Question	White %	BME %
I was satisfied with the response to my concern about suspected wrongdoing	41	27
I was victimised by management after raising a concern	13	21
I was ignored by management after raising a concern are higher	15	19
I was praised by management after raising a concern	7	3
When I gave support to a colleague who raised a concern, I suffered detriment	15	20
I was victimised by co-workers after raising a concern	24	36
I am less likely to report a concern again if I suspect wrongdoing	59	73
I have not raised a concern about suspected wrongdoing report due to a fear of victimisation	14	24

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf
[10] https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review

Source: Robert Francis *Freedom to Speak Up Review* (2015)

14. The NHS National Staff Survey (2023) also found that staff with long-lasting health conditions or illnesses and staff from BME backgrounds are less likely to feel safe to speak up about any concerns they have, compared to White staff.[11]

15. Kline and Somra (2021) found poor treatment of BME staff is likely to have an impact on whether staff raise concerns. Such treatment is also likely to affect what happens if they do raise concerns. Freedom to Speak Up Guardians (FTSUs) reported particular issues about overseas-trained staff who can be anxious about raising concerns due to fear of the consequences (especially if they felt their visas would be jeopardised) or if they had previously worked in a culture in which concerns were not raised.[12]

16. We found confirmation of the specific challenges facing BME staff raising concerns came from both BME and White FTSU Guardians interviewed:

> *"In our trust, there was certainly an issue about overseas staff not speaking up, and the culture of the Trust was generally not conducive. That might be made worse if staff had concerns that raising a concern might have implications for their visas or if there was a culture of not raising concerns as highlighted in COVID."*

17. However, our review of FTSU Guardians found almost no other research considering the experience of BME staff raising concerns, a finding confirmed by a more comprehensive review of FTSU Guardians.[13]

18. Our own more recent research (Kline and Warmington, 2024)[14] surveyed 1,327 BME NHS staff and found that:
    - UK-trained staff are much more likely than internationally trained staff to raise concerns;
    - The most common reason for not raising a concern of race discrimination was not believing anything would change: 63% of staff who didn't raise their concerns were worried about being seen as a troublemaker, and 57% were worried about repercussions from their line manager or other organisational leaders;

[11] https://www.gov.uk/government/statistics/announcements/2023-nhs-national-staff-survey
[12] https://nationalguardian.org.uk/wp-content/uploads/2021/09/Difference_Matters.pdf
[13] https://pure-oai.bham.ac.uk/ws/portalfiles/portal/175158203/JonesA2022Implementation.pdf
[14] www.brap.org.uk/post/toohottohandle

- Of those who did raise concerns, only 5.4% said they were taken seriously and that their problem was dealt with satisfactorily. The most common outcome to a race discrimination concern was nothing happening - the outcome in 42.7% of cases.

19. The most recent comprehensive research on whistleblowing in the NHS found:

> "*There is a dearth of literature focusing on the influence of wider societal intolerances, such as racism or homophobia, on speaking up within health care… although health-care teams often consist of workers from multiple ethnic and cultural backgrounds, the question of speaking up within culturally diverse teams is also overlooked in the literature*."[15]

20. Kline and Somra (2021) asked staff surveyed if an issue they had raised as a concern involved people – workers or patients – being treated differently because of their race, nationality, or ethnicity. BME respondents were far more likely to say their concern involved some element of race-based inequality.

> *"I thought I was doing well although I could tell from individual cases that there were specific issues with BME staff raising concerns. When evidence of more serious problems within the trust was provided I realised I had not sufficiently understood the perceptions or experiences of BME staff."* [16]

3. WHY ARE BME STAFF DETERRED FROM RAISING CONCERNS?

21. Research consistently shows two main reasons why people do not raise concerns: first, a belief that if they do the matter would not be rectified; and second, a fear of retaliation. Thus, Sir Robert Francis (2015) found NHS staff in general may be reluctant to speak up because of fear of being:
    - blamed or scapegoated
    - discriminated against
    - disbelieved
    - seen as disloyal
    - seen as disrespectful in a hierarchical system
    - bullied
    - and the wider consequences for their career.[17]

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[15] https://pure-oai.bham.ac.uk/ws/portalfiles/portal/175158203/JonesA2022Implementation.pdf
[16] https://nationalguardian.org.uk/wp-content/uploads/2021/09/Difference_Matters.pdf

22. In their most recent report, the National Guardian's Office (2023) found that:
    - Almost two-third of respondents (66%) identified futility (i.e., the concern that nothing will be done) as being a 'noticeable' or 'very strong' barrier to workers in their organisation speaking up and this was an 8% increase compared to responses in the previous survey (58% 2021).
    - Two-thirds of respondents (66%) identified retaliation/suffering as a result of speaking up as being a noticeable or very strong barrier to speaking up.[18]
23. Research has reported the importance of hierarchy as a deterrent to raising concerns and BME staff are more likely to be found in junior and middle grades – or as agency and contractor staff – than White staff.[19]

24. In research beyond the NHS, but including NHS respondents, Reitz and Higgins (2020) reported that respondents rated their own likelihood of speaking up and listening up more highly in most cases than they rated others. In other words, they felt that they spoke up and listened up, but others did not: a "superiority illusion". Reitz found 88% of senior respondents said that race never or rarely affected how they listen to others. Ninety per cent insisted gender did not affect how they listen. The researchers comment:

    "This is highly unlikely to be the case. Just because we don't want these things to get in the way, doesn't mean that they don't. Leaders must face up to their own unconscious bias—one way to do this is to really notice their response to different people as they speak up."[20]

25. Hierarchy is compounded by the patterns of discrimination whereby BME staff are:
    - more likely than their White colleagues to be bullied by their managers and colleagues
    - more likely than their White colleagues to enter the formal disciplinary process
    - much more likely to experience discrimination from managers and colleagues)[21]

26. The annual NHS staff surveys (and other evidence) consistently show that BME staff experience higher levels of bullying, incivility, and discrimination than White staff do. The prevalence of bullying in the NHS has been long reported and analysed.[22] Messenger (2022) found:

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[17] https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review
[18] https://nationalguardian.org.uk/2023/06/08/fear-and-futility/
[19] https://pure-oai.bham.ac.uk/ws/portalfiles/portal/175158203/JonesA2022Implementation.pdf; see also https://bmjleader.bmj.com/content/5/4/270
[20] https://bmjleader.bmj.com/content/leader/early/2020/11/06/leader-2020-000394.full.pdf
[21] https://www.nhsstaffsurveys.com/results/national-results/
[22] http://workstress.net/sites/default/files/PopeBurnes.pdf

"The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance."[23]

4. SO, WHAT SHOULD BE DONE?

General concerns

27. A review of changes in board leadership and governance since the Francis Review found:

"*Boards [are]… focussed on reputation and image rather than substance… outwardly projecting an image of success whilst not having grip on operational performance*".[24]

28. After Lucy Letby's jailing, the former Trust chair Sir Duncan Nichol, claimed the Board was "misled" by hospital executives, and said it was told there was "no criminal activity pointing to any one individual" after two hospital-commissioned reviews in late 2016.[25] Apparently none of the board members were sufficiently curious to pop down and talk to the doctors who had repeatedly raised serious concerns.

29. Inquiries into similar failings in other Trusts into the raising of concerns have repeatedly shown that:
    - the failure to be curious and create a culture where staff who raise concerns are seen as "gold dust" not as troublemakers is commonplace
    - reputation management, which often means avoiding an appropriate response to staff raising concerns, is familiar in many NHS organisations
    - staff who hesitate to raise concerns do so either because they believe doing so will not be successful and may make things worse for them personally

30. NHS England's exhortation to NHS Boards and staff to ensure concerns are raised is evidence-free. Wu et al (2021) suggest that

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[23] https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future
[24] https://research.manchester.ac.uk/en/publications/responses-to-francis-changes-in-board-leadership-and-governance-i
[25] https://www.theguardian.com/uk-news/2023/aug/20/lucy-letby-nhs-trust-chair-says-hospital-bosses-misled-the-board

"the addition of further layers of formal policy may provide a veneer of order without enhancing understanding."[26]

31. Reitz and Higgins (2020) also conclude that: "*instigating whistleblowing lines and training employees to be braver or insisting that they speak up out of duty, will achieve little without leaders owning their status and hierarchy, stepping out of their internal monologue and engaging with the reality of others*.'" [27]

32. This is particularly important as further procedural initiatives, such as regulating managers (announced following the outcome of the trial of Lucy Letby[28]) will not, in isolation, drive culture change (especially if they are policed by NHS England or a DHSC body). As has been argued elsewhere:

> *"a primary reliance on policies, procedures and training will not, in isolation, reduce bullying, improve the effectiveness or safety of whistleblowing, (or) create a disciplinary environment focused on learning*."[29]

33. Senior staff and NHS Board members are already supposed to follow the Nolan Principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. Regulation for managers is a performative gesture unless accompanied by other measures.

Specific challenges in ensuring the voice of BME staff is heard, listened to, and acted upon

34. A decade ago, research into organisational behaviour in the NHS concluded:

> *"The NHS exhibits too high a level of collective ego defences and protection of its image and self-esteem, which distorts its ability to address problems and to learn. Organisations and the individuals within them can hide and retreat from reality and exhibit denial; there is a resistance to voice and to 'knowing'".*[30]

35. This is exacerbated if the concern raised by BME staff is about racism or bullying. In *Too Hot To Handle?* (2024) our report found racially minoritised staff face common responses when raising concerns about race equality. These include:

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[26] https://pubmed.ncbi.nlm.nih.gov/34051553/
[27] https://bmjleader.bmj.com/content/leader/early/2020/11/06/leader-2020-000394.full.pdf
[28] https://www.england.nhs.uk/long-read/verdict-in-the-trial-of-lucy-letby/#verdict-in-the-trial-of-lucy-letby
[29] https://bmjleader.bmj.com/content/leader/early/2023/05/17/leader-2022-000729.full.pdf
[30] http://workstress.net/sites/default/files/PopeBurnes.pdf

- denial: often staff were subjected to 'poor behaviours' but neither managers nor subsequent investigations felt they could name the race discrimination that lay behind these behaviours
- reluctance or refusal to acknowledge race as an issue: connected with the above, employers tend to resist acknowledging poor treatment as race discrimination often, it seems, because of the stigma attached
- minimising of harm: organisations go to great lengths to downplay the impact of racist behaviours
- a lack of empathy: racially minoritised staff do not always receive compassion and understanding when raising concerns. Indeed, it is more common they are met with frustration, defensiveness, and exasperation[31]

36. In addition, there are common shortcomings in race-related investigations:

- many employers set an unnecessarily high bar requiring staff to prove any allegation of race discrimination was 'racially motivated'
- tackling racism is seen as too difficult and so is avoided
- the process of raising a concern and the time an investigation takes deters staff from raising a concern
- staff lack confidence investigatory processes and other responses will be fair

37. These findings correlate with findings from a number of Employment Tribunals we reviewed where BME staff had successfully sued NHS employers over their treatment when raising concerns, notably the successful landmark claim by Michelle Cox, a Black nurse manager, who whistle blew about the treatment of patients and was victimised for doing so.

38. As part of our response to these findings we critiqued existing approaches to addressing racism, and considered why racism is not better understood and considered what organisations could do if they were serious in their intentions to respond more effectively to both overt and covert forms of racism.

39. We suggest NHS organisations can create a culture freer from race discrimination by:

- developing an appetite for 'race talk' and setting standards of behaviour that challenge 'everyday' racism

[31] https://www.brap.org.uk/post/toohottohandle

- developing greater levels of comfort in staff speaking out about racism and ensuring concerns are acted on without retaliation
- acting on the early warning signs of racism by tackling racism more informally and being proactive when evidence would suggest there might be a problem
- imparting the skills that all staff need to get closer to genuine anti-racist practice, with particular development needed for boards, leaders, and professionals whose roles directly uphold the values of their organisations.

40. Crucially, there needs to be a learning culture where staff can be confident they will be heard, listened to, and their concerns acted on, without risk of resultant detriment. The culture and behaviours – the organisational deafness – of those with authority is the prime obstacle.

41. This is even more so with BME staff because organisations and managers become more defensive, placing individual and organisational reputational risk ahead of addressing concerns raised by BME staff, engaging in denial and avoidance and focusing on comfort-seeking rather than problem-sensing, even more than they do with staff in general. That is what our survey and the Employment Tribunal cases we considered show, even more so than generic recent whistleblowing research.
42. We suggest that whilst early informal resolution may be preferred to draw out processes that deter others and damage those involved, where this is not possible there needs to be assurance that attempts to prevent workers (including agency and contractor staff) or patients/relatives raising reasonably held beliefs about patient safety and worker wellbeing (including race discrimination), or any attempt to cause detriment to any such individuals, is regarded as gross misconduct. Boards need to end the protection and recycling of individuals engaged in race discrimination.

43. Doing so will make a very significant contribution to patient care and safety, alongside a recognition of the detrimental impact of unchallenged racism on NHS staff of BME heritage. We urge you to make explicit recommendations about this issue, far too long the subject of avoidance, denial, and collusion to the detriment of patient care and safety, organisational effectiveness, and staff health and wellbeing.

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