patient safety learning

We are not getting safer: Patient safety and the NHS staff survey results

26 March 2024

Patient Safety Learning

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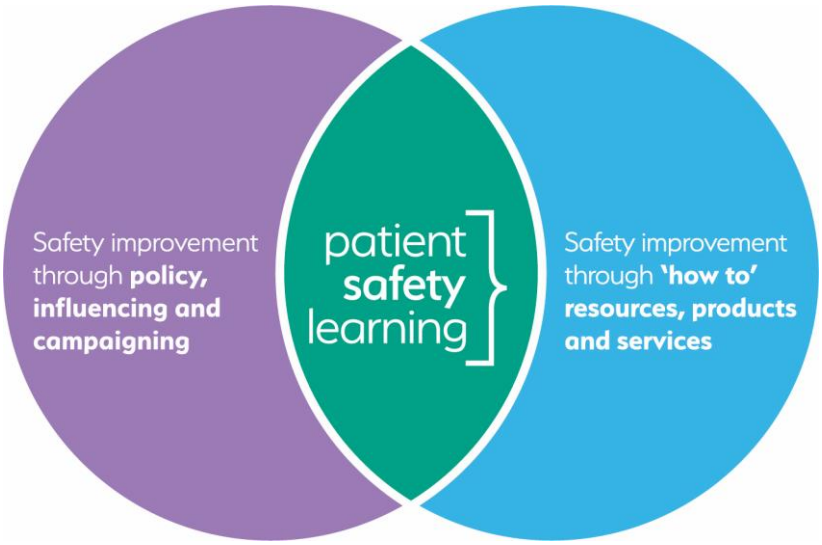
We harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm. We believe patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Through our work we support safety improvement through policy, influencing and campaigning, and the development of 'how to' resources such as *the hub*, our free award-winning platform to share learning for patient safety, and our unique *Patient Safety Standards and support tools*.



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Executive Summary

This report analyses the results of questions in the NHS Staff Survey 2023 specifically relating to reporting, speaking up and acting on patient safety concerns. It raises questions as to why there has been so little progress despite policy intention in this area. It concludes by setting out the need to improve the implementation, monitoring and evaluation of work seeking to create a safety culture across the NHS.

Survey results: Reporting of errors, near misses and patient safety incidents

We examine the latest survey results in two parts, first looking at responses to questions in the 'Patient Safety' section of the staff survey. These include several concerning statistics, with strikingly over 40% of staff unable to say with confidence that their organisation treats them fairly if they are involved in an error, near miss or incident. We also point to a trend in responses to several of these questions for Ambulance Trusts, who perform particularly poorly compared to other organisation types.

Survey results: Concerns about clinical safety and speaking up

Turning to questions on clinical safety, the responses to this year's survey show that the percentage of staff who feel secure raising such concerns is now at a five-year low. We note that it is difficult to imagine that such figures in other safety critical industries, where the consequences of incidents may also be serious injury or loss of life, would be deemed acceptable. Surely this must be unacceptable in healthcare. Looking at responses on speaking up, again we see concerning figures. More than 260,000 staff are unable to say that they felt safe to speak up about anything that concerns them in their organisation. We also highlight significant variation in answers to these questions related to the ethnic background of the respondent.

Scandals and whistleblowers: Further areas of concern

Acknowledging that the staff survey only provides an annual snapshot of experiences working in the NHS, we consider where these findings are reinforced by evidence we see elsewhere. Patient safety scandals and testimonies of whistleblowers point to the continued persistence of blame cultures in significant parts of the health system.

National Patient Safety Strategy: Safety culture activities in the NHS

Considering the evidence presented in the previous sections of the report, we consider the activities that NHS England is currently undertaking to create a safety culture. Five years into the National Patient Safety Strategy, we note some positive progress in introducing new guidance and information, but a lack of clarity and focus on plans for implementation and evaluation.

Implementation, monitoring and evaluation: The need to move from theory to practice

We make the case that there needs to be a more transformative effort and commitment to creating a safety culture in the NHS. We believe there need for more examples of practical implementation of culture change, and make two specific recommendations for further action based on this report:

- **NHS England and Integrated Care Systems should set out how they will support and ensure the effective and consistent implementation of safety culture guidance and best practice across the country.**
- **NHS England should set out actions to seek to address the discrepancies identified in responses on patient safety and speaking up specifically concerning Ambulance Trusts and the ethnic background of respondents.**

To conclude we set out some final thoughts on developing a safety culture in the NHS.

Introduction

On 7 March 2024, the NHS published the results of its 2023 staff survey.[1] This is one of the largest workforce surveys in the world, with employees asked on an annual basis about their experiences of working for their organisations. Of the 1.4 million NHS employees in England, 707,460 responded to the survey in 2023; just over 50% of all staff.

In this survey staff are asked several questions specifically relating to reporting, speaking up and acting on patient safety concerns. This report analyses the responses to these questions, considering what they can help tell us about patient safety in England and the persistence of blame cultures in parts of the health system. It goes on to consider further sources of evidence that support these findings and the activity being undertaken by NHS England to tackle this.

The report raises questions as to why there has been so little progress despite policy intention and concludes by setting out the need to improve the implementation, monitoring and evaluation of work seeking to create a safety culture across the NHS.

Survey results: Reporting of errors, near misses and patient safety incidents

In the staff survey there are several questions in the 'Patient Safety' section about the reporting of errors, near misses and patient safety incidents. These resulted in the responses listed in Figure 1.

Figure 1: Responses to questions on the reporting of errors, near misses and incidents in the NHS staff survey

- 33.19% of staff have seen errors, near misses or incidents that could have hurt staff and/or patients/service users in the last month (2022: 33.40%).
- 59.45% of staff said their organisation treats staff who are involved in an error, near miss or incident fairly (2022: 58.17%).
- 86.33% of staff said their organisation encourages staff to report errors, near misses or incidents (2022: 86.07%).
- 68.15% of staff said that when errors, near misses or incidents are reported, their organisation takes action to ensure that they do not happen again (2022: 67.37%).
- 60.92% of staff said that they are given feedback about changes made in response to reported errors, near misses and incidents (2022: 59.80%).

Questions around patient safety have been included in previous iterations of the staff survey. However, due to changes in the phrasing and format of the survey it is not possible to make like-for-like comparisons with responses to similar questions prior to the 2022 survey. Even without the ability to make historic comparisons, there are some important issues raised by this set of results.

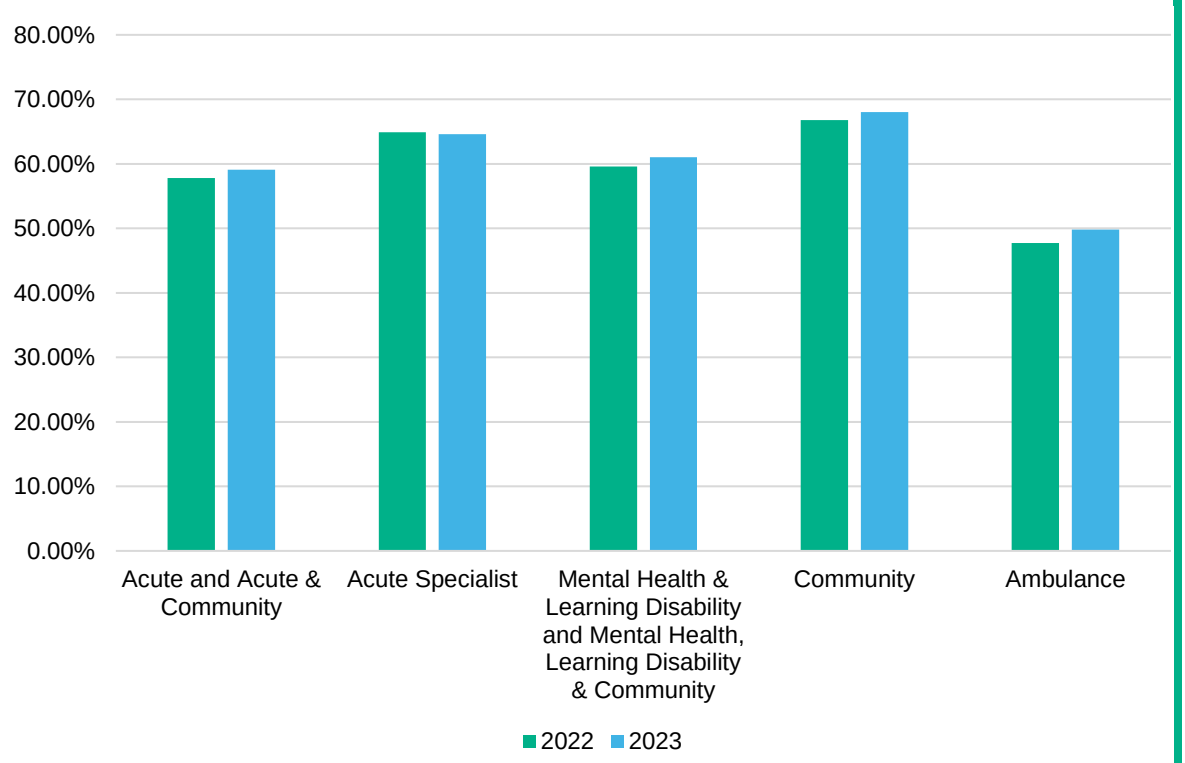
Fair treatment of staff involved in safety incidents

It is a deeply concerning finding that over 40% of staff cannot say with confidence that their organisation treats them fairly if they are involved in an error, near miss or incident. This

year's response marks a marginal improvement from 2022, with an increase of just over 1%. However, this is little consolation for the more than 280,000 staff who have serious reservations about how their organisation treats those who raise safety concerns.

Responses to this question differ significantly depending on where a staff member works, as illustrated below in Figure 2.

Figure 2: Responses to the question 'My organisation treats staff who are involved in an error, near miss or incident fairly' by organisation type



Ambulance Trusts perform particularly poorly in this area, with only 49.82% of respondents answering that they would be treated fairly. This trend is also present when analysing these results by occupation group, with only 47.67% of Ambulance (operational) staff answering that they would be treated fairly.

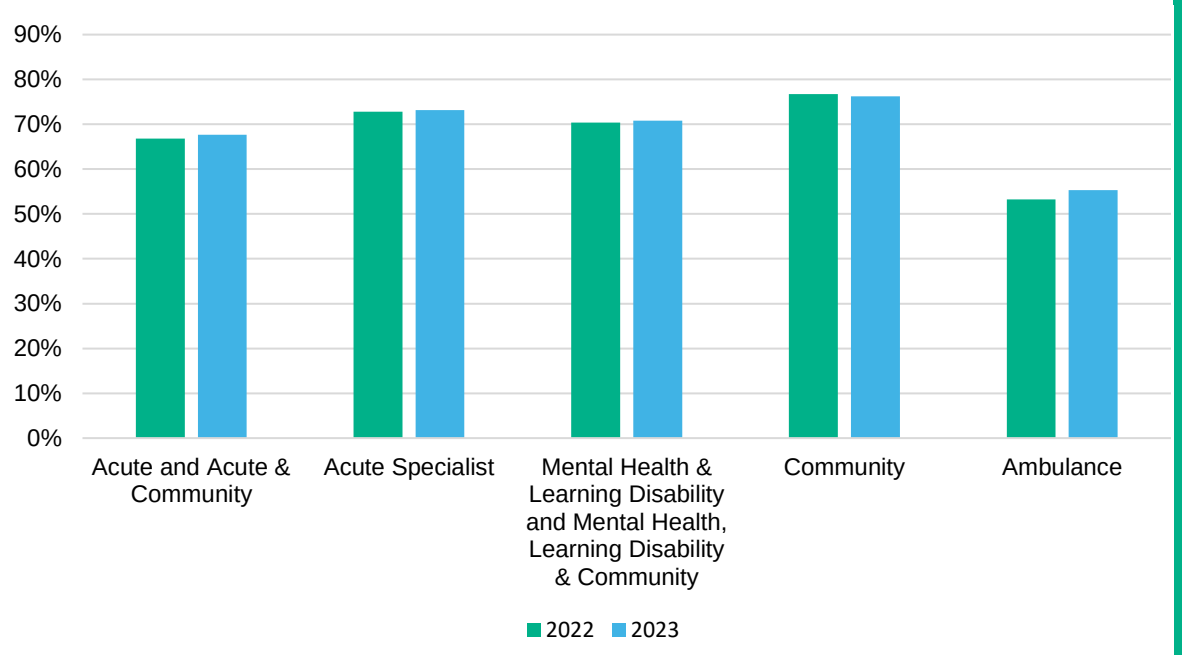
Reporting concerns and taking action

86.33% of staff, a small increase on 86.07% in 2022, answered that their organisation encourages staff to report errors, near misses or incidents. Compared to responses on the other patient safety questions asked in this survey, this is an area that appears to stand out more positively.

However, it is important that the patient safety messages being sent out by organisations are matched by corresponding attitudes of openness and support for learning and improvement. As we will consider in the next section, these high response rates regarding what organisations say on patient safety sit uncomfortably with responses concerning how staff feel about speaking up.

Turning from reporting concerns to acting on them, a significant number of respondents (31.85%) felt unable to say that when errors, near misses or incidents are reported, their organisation takes action to ensure that they do not happen again. It is a serious point of concern that this is the perception of over 220,000 NHS employees. As with the 'fair treatment of staff' question, responses to this vary significantly depending on where someone works, as illustrated in Figure 3.

Figure 3: Responses to the question 'When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again' by organisation type



Again, we find that Ambulance Trusts have the lowest responses to this question. In 2023, only 55.33% of Ambulance Trusts respondents said that their organisation takes action to ensure that reported errors, near misses or incidents do not happen again. This is over 10 percentage points lower than the next lowest organisation type (Acute and Acute & Community Trusts on 67.69%) and more than 20 points lower than respondents from Community Trusts (76.22%).

The significant numbers of staff not being able to say that their organisation acts to ensure incidents do not happen again is perhaps reinforced by their answers to the question "are staff given feedback about changes made in response to reported errors, near misses and incidents?". Nearly 40% of staff were not able to answer this positively. It may be that action is being taken but that staff are unaware of this, either in their own working environment or more broadly; however, this also may suggest that some staff reflect that the action being taken is insufficient.

For many organisations, accountability and transparency around patient safety performance and improvement is inadequate. If staff are unable to clearly see their organisation's approach to learning and acting on safety concerns, there is little hope that patients and the public will get a clear understanding of this. Open assessment and reporting on patient safety is vital if we are to have confidence that NHS leaders are taking this issue seriously.

Survey results: Concerns about clinical safety and speaking up

Concerns about clinical safety

In the 'We each have a voice that counts: Raising concerns' section of the survey there are two questions about clinical safety, detailed below in Figure 4.

Figure 4: Responses to questions on concerns about clinical safety in the NHS staff survey

- 71.28% of staff said they would feel secure raising concerns about unsafe clinical practice (2022: 71.89%).
- 56.81% of staff said they were confident that their organisation would address their concern (2022: 56.73%).

The percentage of staff saying they would feel secure raising concerns about unsafe clinical practice is almost identical to 2019 (71.85%), the year when the NHS Patient Safety Strategy was launched. As noted by NHS England in its *National results briefing*:

> "When it comes to concerns about clinical safety, the percentage of staff who feel secure raising such concerns is now at a five-year low. Confidence to raise clinical safety concerns has declined by around six percentage points amongst medical and dental staff since 2021."[2]

The response rate in 2023 means that over 200,000 NHS employees could not say that they would feel secure raising concerns about unsafe clinical practice. When breaking this down by organisation type, as illustrated in Figure 5, again we see that Ambulance Trusts perform worse than their counterparts.

Figure 5: Responses to the question 'I would feel secure raising concerns about unsafe clinical practice' over the past five years by organisation type

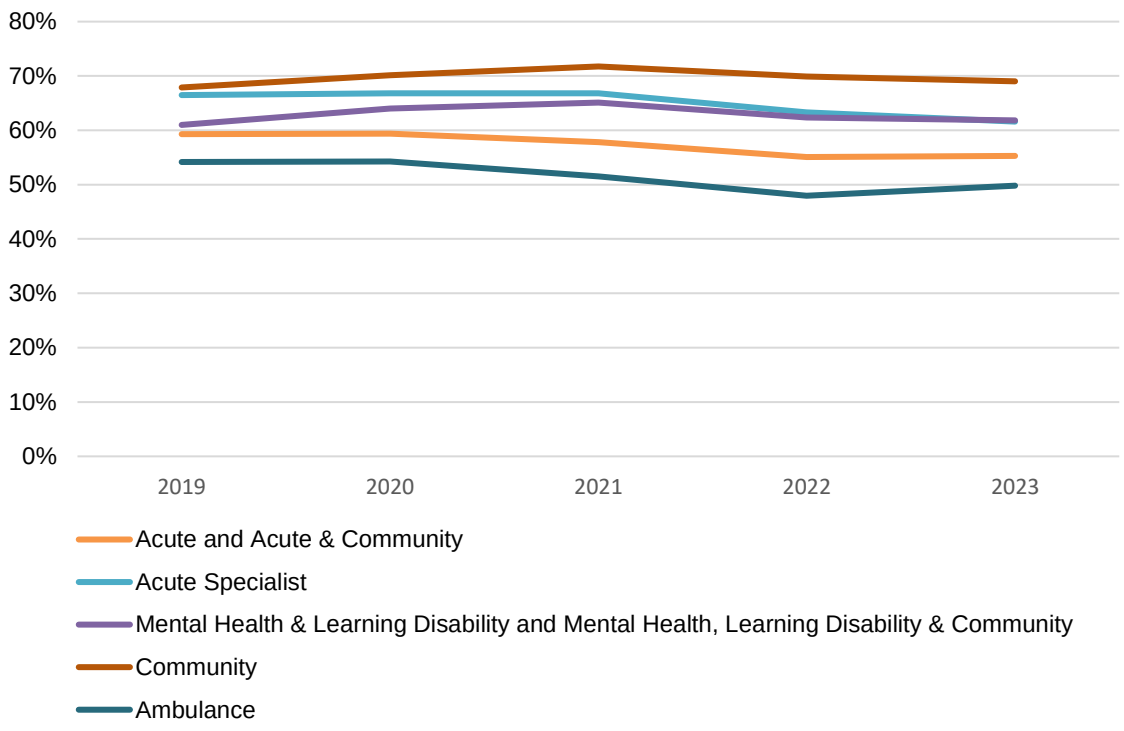
Organisation type	2019	2020	2021	2022	2023
Acute and Acute & Community	71.37%	71.86%	73.75%	70.61%	69.96%
Acute Specialist	74.60%	74.80%	77.67%	74.50%	72.72%
Mental Health & Learning Disability (LD) and Mental Health, LD & Community	73.61%	75.57%	79.51%	76.81%	76.24%
Community	77.44%	79.04%	82.75%	80.94%	79.81%
Ambulance	65.84%	67.91%	70.15%	65.09%	65.71%

Turning to the second clinical safety question, 43.19% of respondents could not say that they were confident that their organisation would address any clinical practice concerns raised. This is more than 300,000 NHS employees.

The percentage of staff responding positively to this question is currently lower than when the NHS Patient Safety Strategy was launched (56.81% now compared with 59.90% in

2019). As illustrated in Figure 6, once again Ambulance Trusts perform worst in this area, with a nearly twenty percentage point difference when compared to Community Trusts (49.82% against 69.03% in 2023).

Figure 6: Responses to the question 'I am confident that my organisation would address my concern' over the past five years by organisation type



This year's survey results highlight little change in the scores around clinical practice and safety in the past five years. It is difficult to imagine that such figures in other safety critical industries, where the consequences of incidents may also be serious injury or loss of life, would be deemed acceptable. Surely it must be unacceptable in healthcare.

Speaking up about concerns

The remaining two questions in the 'We each have a voice that counts: Raising concerns' section of the staff survey are on speaking up about concerns, detailed in Figure 7.

Figure 7: Responses to questions on speaking up about concerns

- 62.31% of staff said they feel safe to speak up about anything that concerns them in their organisation (2022: 61.52%).
- 50.07% of staff said they were confident that their organisation would address their concern (2022: 48.69%).

37.69% of respondents, more than 260,000 staff, could not say that they felt safe to speak up about anything that concerns them in their organisation. When asked about their confidence in their organisation acting on any concerns, the picture looks worse, with

49.93% of respondents not having confidence that their concerns would be addressed. This is more than 350,000 NHS employees.

It is a shocking figure that over a third of NHS staff surveyed do not feel safe to speak up about concerns. As referred to in the previous section, this sits awkwardly with a response from 86.33% of staff that their organisation encourages staff to report errors, near misses or incidents. This appears to indicate there is a significant gap between what NHS organisations say to employees about patient safety and creating the conditions where they feel safe to follow this advice. When compared with previous years, survey scores appear to be stagnant, as illustrated in Figure 8.

Figure 8: Responses to questions on speaking up about concerns over the past four years

Question	2020	2021	2022	2023
I feel safe to speak up about anything that concerns me in this organisation.	65.67%	62.06%	61.52%	62.31%
If I spoke up about something that concerned me, I am confident my organisation would address my concern.	No data	49.81%	48.69%	50.07%

There is also significant variation in answers to questions related to the ethnic background of the respondent. When asked whether they feel safe to speak up about anything of concern in an organisation:

- The two highest performing groups, 'Asian/Asian British – Indian' and 'Black/African/Caribbean/Black British – African' score just under 2% higher than the national average at 64.28% and 64.02%, respectively.
- The group 'White - English / Welsh / Scottish / Northern Irish / British', who make up most survey respondents (459,079) score just above the national average at 63.75%.
- The lowest performing group, 'White – Gypsy or Irish Traveller', a relatively small number of employees (442), score over ten points below the national average at 39.40%.
- The next four lowest performing groups all fall at least five points below the national average, within a range of 51–55%. This accounts for 24,906 staff in total, from the following groups:
    - Black/African/Caribbean/Black British – Caribbean.
    - Mixed/Multiple ethnic background – Any other Mixed / Multiple ethnic background.
    - Other ethnic group – Any other ethnic background.
    - Black/African/Caribbean/Black British – Any other Black / African / Caribbean background.

A similar trend emerges when asked about their confidence that organisations would address concerns:

- The two highest performing groups, 'Black/African/Caribbean/Black British – African' and 'Asian/Asian British – Indian', scored significantly higher than the national average at 59.26% and 58.94%, respectively.
- The lowest performing group again, 'White – Gypsy or Irish Traveller', scored over twenty points below the national average at 29.62%.

- The next four lowest performing groups were again the same as in the previous question. They scored within a range of 42–44%, significantly lower than the national average.

This is not a new issue, with last year's analysis of the staff survey results by the National Guardian's Office highlighting similar trends in the previous two years of results concerning speaking up in the NHS.[3]

Overall, the results in this section of the survey are a clear indication that we remain far away from the NHS vision of creating a patient safety culture throughout the health service.

This also evidences what is often described as the difference between 'work as imagined' versus the 'work as done'. Organisational leaders often feel a false sense of confidence that their stated commitment to listening and acting on concerns from staff and patients is translated to action. The staff survey results appear to demonstrate that this a significant gap between what is said by many organisations and how staff feel. This needs to be addressed, to ensure intention leads to action, with staff feeling confident that their voices are listened to, and their insights are making a difference for patient and staff safety.

Scandals and whistleblowers: Further areas of concern

The latest survey results indicate that in many parts of the health service, staff do not feel safe to speak up, or have confidence that their concerns are being listened to and acted upon. While it is important to acknowledge that this only provides an annual snapshot of experiences working in the NHS, these findings are reinforced by evidence we see elsewhere.

We see that the fear of speaking up appear repeatedly in major patient safety scandals. Most recently, the maternity inquiries at Shrewsbury and Telford and East Kent have raised such concerns, echoing past reports such as the Mid Staffordshire Review.[4] [5] [6] Cultures of blame have continued to emerge as an underlying cause of avoidable harm for over two decades as highlighted in many different inquiries and reviews.[7]

Further evidence of staff not feeling safe to speak up, and suffering severe repercussions when they do, are reflected by the shocking experiences and testimonies of whistleblowers in healthcare. Prominent recent cases, such the experience of Peter Duffy, have highlighted serious concerns about the culture in parts of the NHS.[8] [9] [10]

Too often, staff raising patient safety concerns to their organisation are met with a hostile and aggressive response, rather than one that is open and welcomes to challenge and scrutiny. Staff often experience receive legal threats, vexatious referrals to regulatory bodies, pay cuts, demotions, disciplinary action and contractual changes. They continue to face experiences like this when they go on to raise concerns to organisations such as the Care Quality Commission (CQC) or other external agencies, with organisational responses often marked by a focus on reputation management over tackling safety concerns.

Such responses to raising concerns have recently been highlighted in the prosecution of Lucy Letby, who was found guilty of murdering seven babies on a neonatal unit at the Countess of Chester Hospital.[11] The consultant who first raised concerns about Lucy Letby's behaviour, and other clinicians involved in this case, have highlighted issues regarding the hospital's response and a failure to act appropriately on the information provided.[12] These

issues have been identified as an area for further investigation in the terms of reference of the public inquiry led by Lady Justice Thirlwall looking into the Letby case.[13]

Concerns from across the sector

Coupled with the staff survey results, it would be hard to make the case that blame cultures do not continue to significantly persist in the NHS. This is an issue that Patient Safety Learning have continued to highlight with reference to the staff survey results year on year and since 2020.[14] [15] [16] [17]

We see fears and reluctance to speak up often manifest themselves in our work when sharing healthcare professionals' stories on *the hub*, our platform to share learning for patient safety. Staff will share serious concerns anonymously, but often do not have the confidence or security to speak up within their organisations. [18] This echoes views expressed in the staff survey.

We also highlighted these issues in a recent submission to the Health and Social Care Select Committee's Independent Expert Panel.[19] The Panel have evaluated and reported on several public inquiry and review recommendations on patient safety which have been accepted by the Government, including recommendations from the 2015 Francis Review into creating an open and honest reporting culture in the NHS.[20] [21] [22]

We are not the only organisation who have been raising concerns about culture and patient safety in the NHS nationally. In a report analysing last year's staff survey results, the National Guardian's Office highlighted concerns about the number of staff who do not feel able to speak up and the need for this to be urgently addressed.[23] They also noted from their own survey of Freedom to Speak Up Guardian's in 2023 a decline in the perception of improvements in the speak up culture of the healthcare sector.[24]

Elsewhere, the Patient Safety Commissioner for England has identified the need to deliver a just and learning safety culture as one of her three priority areas in her strategy.[25] The Parliamentary and Health Service Ombudsman has highlighted these issues on numerous occasions, and in a report last year called for the Government to seek cross-party support for embedding patient safety and the culture and leadership needed to support it as a long-term priority.[26] The Professional Standards Authority has also recently highlighted the persistence of ongoing cultural concerns to the NHS in a submission to the Health and Social Care Select Committee.[27]

National Patient Safety Strategy: Safety culture activities in the NHS

Against this evidence of the continued persistence of blame cultures in the health system, NHS England is undertaking a number of activities seeking to tackle this.

Published in July 2019, the NHS Patient Safety Strategy identifies a patient safety culture as one of the two foundations required in working towards its safety vision "to continuously improve patient safety".[28] Figure 9 sets out the activities NHS England are undertaking in relation to this in an update on the Patient Safety Strategy.

Figure 9: Extract from the NHS Patient Safety Strategy: 2021 update[29]

1. Monitor the development of a safety culture in the NHS

- Assess whether additional safety culture questions in the staff survey would have value by Q4 2020/21.
- Complete a discovery phase for a safety culture data 'visualisation tool' by Q2 2021/22, which includes identifying potential new metrics related to safety cultures in the scope.
- Explore the safety culture characteristics of highly safe NHS trusts, and share insights by Q1 2021/22.

2. Support the development of a safety culture in the NHS

- Establish the safety culture work programme to bring together data, research and practical support for safety culture improvement by Q1 2021/22.
- Produce a safety culture guide to help organisations implement specific improvement activities by Q1 2021/22.
- Extend the exploration of safety culture processes and infrastructure to mental health, community and primary care settings by Q4 2021/22.
- Continue to establish and test safety culture interventions to support local systems, as part of the key enablers objective.

New guidance

A new Safety Culture Programme Group met in July 2021 to discuss recommendations to develop a safety culture in the NHS.[30] This led to the decision to create a new Safety Culture Implementation Group to meet every 2–3 months to oversee this work. Subsequently, NHS England has published the following good practice resources:

- Safety culture: learning from best practice (November 2022) – this identifies six themes from discussions of good practice and case studies related to this.[31]
- Improving patient safety culture – a practical guide (July 2023) – a toolkit intended to give teams an understanding of how to craft and nurture a positive safety culture and provide a theoretical underpinning to how to shift culture.[32]

Additionally, there is also A just culture guide available on the NHS England website, which "encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way".[33]

The above is what Patient Safety Learning considers to be an accurate summary of NHS England's activities in this area since the launch of the Patient Safety Strategy to date. The core thrust of this has been the creation of new central resources and guidance to support organisations move towards a safety culture. However, we would note that the membership and activities of the Safety Culture Implementation Group is not shared in the public domain; therefore, there may be other work underway that, to date, we are unaware of. We would welcome greater transparency around NHS England's activities in this area.

Implementation, monitoring and evaluation: The need to move from theory to practice

NHS England have made some positive progress in introducing new guidance and information, but currently we are not clear on plans for implementation.

The staff survey results indicate that blame cultures and a fear of speaking up continue to persist in a significant part of the NHS. Coupled with findings of patient safety inquiries and whistleblower testimonies, this demonstrates the need for a more transformative effort and commitment to creating a safety culture. In this final section we consider what this would look like and make two recommendations.

Sharing good practice and learning

Although the NHS guidance produced to date is useful, we believe that a greater pool of resources is required to meet the scale of this challenge. This includes not only good practice guidance, but also examples of practical application for organisations to implement a safer culture.

Examples of implementation in practice
We know there are specific organisations, such as Mersey Care NHS Foundation Trust, who have over many years committed to making significant changes in culture.[34] We believe it would be greatly beneficial for the NHS to explore how it can help organisations such as Mersey Care and others share their practical experience of implementing culture change programmes with other organisations.

The *Safety culture: learning from best practice guide* published by NHS England that we referenced in the last section includes links to three case studies from Trusts setting out examples of good practice. This might provide a useful starting point for further expand resources on this.

While good practice guidance and theory is helpful, we believe there also needs to be a significant focus on practical implementation of these changes. There is currently new research being undertaken in this area by Northumbria University. They are exploring experiences of NHS Trusts who have attended and implemented changes as part of their joint programme with Mersey Care, Principles and Practices of Restorative Just Culture.[35] While this is to be welcomed, we believe this work needs to be expanded with ongoing, funded, collaboration to drive culture change.

Patient Safety Standards
We believe that one of the primary reasons for the persistence of avoidable harm is that healthcare does not have or apply standards of good practice for patient safety in the way that it does for other issues. Standards that do exist are insufficient and inconsistent. At Patient Safety Learning, we believe that health and social care organisations need to have standards for patient safety. These can inform 'what good looks like' and enable organisations to self-assess against them, helping them prioritise their patient safety improvement activities.

Based on our original research and policy document *A Blueprint for Action*, Patient Safety Learning has developed a set of unique patient safety standards centred around seven key foundations for patient safety:[36] [37]

- Leadership and Governance
- Culture
- Shared Learning
- Professionalisation of Patient Safety
- Patient Engagement
- Data and Insight
- Delivery of Patient Safety Services.

The Standards that we have developed in response are based on 20 years of research, as well as learning from inquiries, policy and good practice from healthcare, both in the UK and internationally. To meet our Standards on culture, an organisation needs to demonstrate that:

- Its leadership fosters a patient safety culture that tackles blame and fear.
- The working environment actively supports and promotes a culture of patient safety improvement.
- That the role of HR in an organisation is an active one in reinforcing this.

We would welcome an opportunity to discuss with NHS England and NHS organisations how this approach might help to inform their activities in this area and work towards their goal of creating a safety culture in the NHS.

Implementation (recommendation 1)

To move towards change and improvement, we believe that there need to be clearer plans to help organisations to create and maintain safety cultures. This would include details of how NHS England and Integrated Care Systems (ICSs) will support and ensure the effective and consistent implementation of safety culture guidance and best practice across their commissioned health and social care providers. There also needs to be clarity about how the success of this will be monitored and evaluated.

Patient Safety Learning believes it is important to ascertain:

- Which organisations are aware of the safety culture guidance and have made public commitments to implementing this.
- What progress organisations are making in implementing culture change and what impact they are having.

We understand that NHS England is planning to publish a formal update on the implementation of the Patient Safety Strategy this year. We believe that this would be an opportune moment to build on and expand their activities around creating a safety culture, detailed in Recommendation 1.

Recommendation 1: NHS England and ICSs should set out how they will support and ensure the effective and consistent implementation of safety culture guidance and best practice across the country.

To work towards this recommendation, we would suggest that this could include:

- Clear aims for all organisations:
    - that organisational leaders foster a patient safety culture and tackle blame and fear with a just and learning culture throughout their organisation.

    - that the working environment actively supports and promotes a culture of patient safety improvement.
    - setting out the role of HR in supporting a safety culture.
- Guidance on the role of ICSs as part of this process.
- Processes for identifying poorly performing organisations and intervening if necessary to make improvements.
- Guidance for organisations on developing and transparently publishing and reporting on goals to create a safety culture.
- Sharing practical examples of good practice and how organisations have addressed barriers to change.
- Creating knowledge networks, such as communities of practice, to focus on applying good practice together with peer support and advice.
- Emphasising the need for Executive and Non-Executive leadership to address safety cultures.

Acting on safety themes in this year's staff survey (recommendation 2)

In this report we have identified two underlying issues from the patient safety and speaking up questions in the staff survey that require further investigation.

First, as demonstrated by several questions in this year's survey, staff responding from Ambulance Trusts had noticeably lower scores on a number of safety issues.

This is not a new area of concern. In a review of speaking up at Ambulance Trusts in England last year, the National Guardian's Office also identified this as an area for improvement.[38] NHS England subsequently commissioned an independent review to support the improvement of culture within the ambulance service which published its report in February this year.[39] The review identifies six recommendations as part of this with actions for NHS England, Integrated Care Boards and Ambulance Trusts.

Second, when considering responses to questions concerning staff feeling safe to speak up, there are some significant variations related to the ethnic background of the staff member. Again, this is not a new area of concern, having also been noted by the National Guardian's Office last year.[40]

We believe that in both issues, NHS England should explore how it could seek to address these differences in its safety culture work, detailed in Recommendation 2.

Recommendation 2: NHS England should set out actions to seek to address the discrepancies identified in responses on patient safety and speaking up specifically concerning Ambulance Trusts and the ethnic background of respondents.

To work towards this recommendation, we would suggest that this could include:

- Bringing forward work to respond to the independent culture review of ambulance trusts. This could involve:
    - publishing an action plan in response to this report, setting out how NHS England, working with Integrated Care Boards and Ambulance trusts will respond to this;
    - setting timeframes for implementing the recommendations that NHS England set out in this report.

- Initiating a new workstream/working group to investigate the issues around the ethnic backgrounds of respondents and speaking up as highlighted by the staff survey. This could involve:
    - working jointly with the National Guardian's Office and NHS Race and Health Observatory to form an action plan to tackle these issues.
    - looking at how this work may be integrated into the wider NHS People Plan and its associated activities.

Conclusion: Developing a safety culture

Patient Safety Learning believes that it is vital that we create a culture in healthcare that supports raising, discussing and addressing the risks of unsafe care. As results of this year and previous years staff surveys show, coupled with evidence from patient safety scandals and whistleblower testimonies, in too many parts of the NHS this is simply not the case.

Cultures of blame have continued to emerge as an underlying cause of avoidable harm for over two decades of different inquiries and reviews. In 2013 the Prime Minister commissioned Professor Don Berwick to carry out a review of patient safety in the NHS following the breakdown of care at Mid Staffordshire Hospitals. A decade later, many of the solutions it cited around culture and safety remain as pertinent as ever, set out in Figure 10 below.

Figure 10: Extract from the Berwick review into patient safety[41]

- Recognise with clarity and courage the need for wide systemic change: All improvement begins with clear recognition and acknowledgement of the need to improve. Building a better, safer NHS will benefit from that recognition and involvement from everyone who has a contribution to make to health and care – not just the directly funded NHS, but also contractors and partners, large and small healthcare businesses, social enterprises and voluntary organisations, local authorities, privately funded carers, and, of course, patients, carers and communities. Everyone.

- Abandon blame as a tool. Trust the goodwill and good intentions of the staff, and help them achieve what they already want to achieve: better care and the relief of human suffering. Misconduct can occur and it deserves censure. But, errors are not misconduct and do not warrant punishment.

- Recognise that transparency is essential and expect and insist on it at all levels and with regard to all types of information (other than personal data). The most valuable information of all is information on risks and on things that have gone wrong; and among the most valuable sources of information are the reports and voices of patients, carers and staff. Everyone, including staff, should be free to state openly their concerns about patient safety without reprisal, and there is no place for compromise agreements ("gagging clauses") that prevent staff discussing safety concerns.

We know the scale of the challenge, but we don't fully understand why so little progress has been made in this area. Is it the sheer difficulty of making this change? Is it lack of national or local organisational commitment? Are there too many poor role models, incompetent managers or bullies who enable blame cultures to persist? Why are we failing to learn from

good practice? Can we do more to seek learning from other industries that are tackling blame, fear and the need for culture change? Do we care enough to tackle this endemic failure to act? Or is it something else?

It is vital that we do not normalise or deem as acceptable the continued persistence of blame cultures and a fear of speaking up in large parts of the NHS. This is a significant part of our motivation for publishing this report, and raising these issues year on year in relation to the staff survey, that we raise awareness of the need to act for greater impact.

We hope our recommendations will be considered by NHS England as part of its formal update of the NHS Patient Safety Strategy this year. However, we acknowledge this is only one part of a wider effort needed to truly make progress towards creating a safety culture across the health service. There is significant work needed to implement various outstanding safety and culture recommendations from previous inquiries and reviews, such as Robert Francis QC's review into speaking up in 2015. This report set out a recommendation that:

> "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."[42]

As noted by the Health and Social Care Select Committee's Independent Expert Panel in its recent report, in this respect the work of the Department of Health and Social Care and NHS "requires improvement".[43]

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