An end to the culture of silence in the NHS: the Francis review

The Francis Review into the Mid Staffordshire NHS Foundation Trust highlighted the need for a culture change in the NHS to become more open, transparent and fair in delivering safe, effective and responsive care. However, there has been a continuing problem in the NHS in relation to the treatment of staff who raise genuine concerns and the support, guidance, mentoring and remediation available. A common theme in the exposure of substandard and sometimes unsafe patient care and treatment has been a lack of awareness by the organization's leadership of the existence or scale of the problem. There have been disturbing reports of what happens to those who raise concerns and also a lack of recognition of the consequences of failure by NHS staff to speak up.

The NHS is our society's most valuable institution and the tales and examples of harrowing experiences, both for individuals and their families as well as NHS staff who have raised concerns, have no place in an organization like the NHS which relies heavily on the goodwill of staff and the value and recognition it places on contributions by staff **AQ 1 sense not clear here - can you rephrase? should we just delete the bit from "and the value..." to the end of the sentence?**. Whistle blowers have been subjected to harassment and recrimination which has left many of them isolated, victimised and suffering serious psychological damage. For NHS employees who witness such treatment of staff, this reinforces the belief that it is better to remain silent.

Culture

Central to the Review **AQ 2 which review - Francis 2015?** is the need for development and a change in culture. The six principles identified are linked to each other and are part of an overall integrated approach and strategy. The culture of safety needs to be centred on the premise of shifting away from a blame culture to a culture of sharing, reviewing, auditing and learning from incidents and reports. Not only should staff feel safe to raise concerns but the culture should welcome and encourage staff to do so. ?? **AQ 3 what does - the Francis review? Please clarify?** places a duty on medical staff to highlight safety issues as they become aware of them in their practice.

In addition to a culture of safety, where raising concerns happens automatically, it is important for the NHS to develop a culture that is free of bullying and harassment and which focuses on education, training, remediation and dispute resolution, rather than sanctions, punishment and victimisation.

There is also a need for leading by example, both in terms of putting an end to the climate of fear that has built up in the NHS over a number of years and in developing a culture of safety and learning.

Role of regulators

The GMC **AQ 4 please write out in full?**, in its response **AQ 5 to what - Francis? Please give reference for the GMC response**, said 'the answer is simple to say, less easy to achieve – a culture where doctors and other health professionals feel empowered and supported when they speak up'. In a survey by the Medical Protection Society **AQ 6 Please give reference for this**, almost half of hospital doctors surveyed admitted that they remained fearful of the personal consequences of raising concerns.

Doctors are acutely aware of the importance of preventing harm to patients – this is a fundamental pillar of our professionalism. Doctors have, in fact, a duty and responsibility to act when they believe patient safety is at risk or that patients' care or dignity are being compromised. It is equally important to create an environment and conditions where doctors feel comfortable and encouraged to speak up and an expectation that they will be supported when they do.

This change in culture needs to happen at local, regional, national and at academic and regulatory levels. The CQC **AQ 7 please write out in full?** should use every planned inspection to investigate and comment on how well the service has handled complaints, concerns and serious incidents and use this information as an indicator of the quality of services, leadership and the organization's ability to deliver safe, responsive care. Where the regulators find examples of good practice and an organization supporting staff and raising concerns, confident in the knowledge that they will be listened to and not victimised but taken seriously, then these examples should be disseminated and good practice shared.

Vulnerable groups

Some staff groups may feel more vulnerable in the context of their freedom to speak, because it is harder for them to raise concerns and they may suffer detriment and hardship as a consequence. This includes locum, agency and bank staff, students and trainees, doctors from BME **AQ 8 please write out in full?** groups and staff working in primary care settings.

A national training survey for trainees **AQ 9 which is this - the GMC survey? Please confirm details?** offers an opportunity for trainees to report safety concerns directly to the regulatory bodies **AQ 10 which are the regulatory bodies which you are referring to here other than the GMC?** and the confidential helpline **AQ 11 please give details of this?** offers the same.

- Doctors in training may find it more difficult to voice their concerns because they fear this may affect their career and possibly have a detrimental impact on their ability to apply for **AQ 12 would this be more accurate as ability to obtain further posts?** further training posts
- If there is a lack of feedback having raised a concern this could deter train-

ees from raising issues in the future
- Incorporating the management of concerns into the curriculum may help trainees understand how to handle these situations
- As each trust has a different strategy for handling staff concerns this should be incorporated into trust induction days so all staff are aware of the procedure for reporting concerns if required.

Locum, agency and bank staff are particularly disadvantaged as they may have no formal induction, guidance or knowledge about policies concerning dignity and so on and they may feel they will not be employed again by the organization or through the agency if they raise concerns. In the NHS, BME staff are under-represented in decision making and in strategic groups and also in recognition and wards schemes, coupled with over-representation in national regulatory procedures. This leads to a sense of vulnerability and the staff survey **AQ 13 which survey - please clarify/give reference?** identified issues around reporting concerns, a fear of victimisation and feeling less likely to be commended or supported in raising a concern. A dangerous consequence was that staff would be less likely to support a colleague who had raised concerns and also that they would be less likely to report a concern again.

In relation to staff from primary care, especially in small practices, staff can feel particularly isolated as it is hard to raise concerns without being identified. For those who are not members of a professional body (and the change from PCTs to CCGs **AQ 14 please write out in full? what does this bit in brackets have to do with the previous part of the sentence? please clarify?**), NHS England and local area teams have a lack of clarity in relation to the process for those who may want to raise concerns or seek advice outside the organization.

Open culture and silence

It is important for an organization to have a culture that is open and transparent and one which welcomes people who raise concerns or, more importantly, a culture that is underpinned by an ethos of team working, and giving and receiving feedback.

Talking at the King's Fund, Sir David Dalton said: 'It is not about heroic leadership, it's an approach co-created with the great people around me and not dependent upon me at all' (Kaur, 2014). Two way feedback and regular dialogue and communication are an essential part of continuing to improve practice and, whatever the reason may be for not speaking up and giving feedback – fear, lack of confidence or indifference, if one feels silenced and disempowered then that has an impact on the ability of the individual to do the best job he/she can.

'In the context of health professionals, it is important that they are always performing to the best and 100% of their ability because the consequences of underperformance affect the quality of safety and care **AQ 15 is this underlined bit correct - not the quality and safety of care?**' **AQ where is this quote from?**

Leadership at every level in the organization should recognize that it is important that staff are able to contribute and tell their managers what is really going on in the organization – they have a duty of candour and should recognize that power lies not in remaining silent but in using their voice.

Conclusions

The Francis Review highlights the importance of cultural change in our health service in creating a workplace across the NHS in which raising concerns is normal, good practice, and staff are supported in doing the right thing for their patients.

Front line staff undoubtedly have the best understanding of what is going on when it comes to quality of patient care. Historically, the NHS has frequently failed to act and, too often, those who have raised concerns have felt victimised and unsupported.

The review also holds a mirror up to NHS leadership. The poor treatment of some whistleblowers is a stain on the NHS and undermines the great efforts of staff and some leaders. Patient safety is paramount and this relies on staff having the confidence to report issues, without fearing victimisation or personal loss. In addition it is critical that a culture of encouraging staff to raise concerns is accompanied by a clear and supportive system with a focus on early intervention and the use of mediation.

For all this to become a reality will require every part of the NHS, professional bodies, regulators and all staff, to work together in developing a new culture.

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KEY POINTS

- At every level, the NHS should send a clear message that it welcomes the raising of concerns by staff and that it maintains a safe and learning culture.
- Every CQC **AQ 16 please write out CQC in full?** inspection should investigate how the organization handles complaints and concerns and use the outcomes to raise the quality of well-led, safe and responsive domains.
- National regulators for health professionals should ensure that there are reforms to speed up their processes and improve the way in which doctors who raise concerns in the public interest are treated.
- Staff and managers should receive clear, effective communication and training on how to raise concerns. Those who raise concerns should be supported and given the recognition they deserve.
- There needs to be a focus on early intervention and on the use of mediation where views become entrenched.

complete address details for Kailash Chand?

AQ 19 please indicate where all references should be cited in the text?

Dickson N (???) GMC response to Freedom to Speak Up - Niall Dickson, Chief Executive GMC (www.gmc-uk.org/news/26198.asp **AQ 20 is this the correct web address? If so, this should be referenced as: General Medical Council (2015) GMC welcomes Sir Robert Francis' report into NHS whistleblowing. www.gmc-uk.org/news/26198.asp accessed 12 March 2015**)

Francis R (2013) Francis Inquiry Report into Care Provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. **AQ 21 please give exact web address and exact date this was last accessed?**

Francis R (2015) 'Freedom To Speak Up – An independent review into creating an open and honest reporting culture in the NHS'. ??? **AQ 22 please give exact web address and exact date this was last accessed?**

Kaur M (2014) Nothing strengthens authority so much as silence. www.kingsfund.org.uk/blog/2014/11/nothing-strengthens-authority-so-much-silence (accessed 12 March 2015)

Singh I, Roberts N, Irving R, Singh N (2013) Compassion, care, dignity and respect – the NHS needs culture change. *Br J Hosp Med* **74**(3): 124–5 (doi: 10.12968/hmed.2013.74.3.124)