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‘Speaking Up’ for patient safety and staff well-being: a qualitative study

Rebecca Delpino ,[1] Liz Lees-Deutsch,[2] Bhawna Solanki[3]

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[1]Educator Clinical Skills & Simulation, Education Department, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK
[2]Associate Professor for Nursing and Clinical Academic Nurse, Centre for Care Excellence, University Hospitals Coventry and Warwickshire and Centre for Healthcare Research, Coventry University, Coventry, UK
[3]Senior Lecturer in Public Health, School of Public Health, University of Wolverhampton Faculty of Education, Health and Wellbeing, Wolverhampton, UK

Correspondence to
Rebecca Delpino;
Rebecca.Delpino@uhb.nhs.uk

ABSTRACT

Background Freedom To Speak Up Guardians (FTSUGs) and Confidential Contacts (CCs) were appointed nationally following the Mid Staffordshire inquiry to listen to and support staff who were unable to address concerns through normal channels of communication.

Aim Explore perceptions of an FTSUG and CCs through shared experiences and personal stories.

Objectives (1) Explore perceptions of an FTSUG and CCs. (2) Consider how individuals can be best supported. (3) Improve staff knowledge on speaking up. (4) Understand factors influencing reflections around patient safety. (5) Share exemplars of good practice through use of personal stories to promote a culture of openness to raise concerns.

Method A focus group of eight participants, namely the FTSUG and CCs working within one large National Health Service (NHS) trust, was used to gather data. Data were collated and organised using a created table. Thematic analysis enabled each theme to emerge and be identified.

Conclusion (1) An innovative approach to the introduction, development and implementation of an FTSUG and CC roles and responsibilities in healthcare. (2) To gain insight into the personal experiences of a FTSUG and CCs working within one large NHS trust. (3) To be supportive of culture change with committed leadership responsiveness.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ In England, it is recommended that each National Health Service (NHS) trust appoints a Freedom To Speak Up Guardian (FTSUG) to listen to and support staff with their concerns, supported by Confidential Contacts (CCs). The role of the CCs in England is to provide informal signposting and support to staff who feel that they are being bullied, harassed or victimised. In Scotland, CCs are required to provide an independent support for the whistleblower (or potential whistleblower) and from a European perspective there is now the EU Whistleblowing Directive. The National Guardian’s Office provides support and challenge to the healthcare system on speaking up.

WHAT THIS STUDY ADDS

⇒ Insight into why NHS trust employees are motivated to volunteer themselves into CC roles to support the FTSUG.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This preliminary study paves a foundation for further research to capture successes and failures of FTSUGs and CC support interventions.

INTRODUCTION

Following the Mid Staffordshire inquiry, Sir Robert Francis recommended that each National Health Service (NHS) trust appoints a Freedom To Speak Up Guardian (FTSUG) to listen to and support staff with concerns.[1] FTSUGs support workers to speak up when they feel that they are unable to do so by other routes.[2] FTSUGs would be supported by ambassadors or Confidential Contacts (CCs) within each organisation, who would work alongside them. The FTSUG and CCs can support staff in raising a concern; this could be by raising the concern on their behalf or supporting staff through the process.[2] The aim was to enable an impartial, objective and approachable point of contact for advice for all employees.

The premise was for FTSUGs to have an independent, non-biased view of situations/concerns, provide a listening ear and help to signpost employees towards actions and support. The role is to provide independent support for the whistleblower or potential whistleblower. It is imperative that FTSUGs are not known to employees who seek advice and are not part of the employee’s own team.

From a European perspective there is an EU Whistleblowing Directive.[3] In Scotland, the CC role can be outsourced to help provide a more independent perspective. There are 22 NHS health boards in Scotland and each NHS Scotland board was required to publish their first Annual Whistleblowing Report in 2021–2022.[4] The Scottish government backed some of the proposals set out by Sir Robert Francis’s ‘Freedom To Speak Up’ report.[5] In England, the National Guardian’s Office (NGO) supports the Francis Report findings. The NGO is an operationally independent body funded by NHS Improvement, NHS England (NHSE) and the Care Quality Commission (CQC)[2] providing leadership, support and guidance on speaking up in the NHS.[2] Twenty principles were developed to enable NHS workers to speak up freely at

work, without fear of detriment, and ensure that their concerns are responded to appropriately (see box 1). These underlying principles support safe and more effective clinical services. Since inception in 2016 the NGO delivered support, training and guidance for FTSUGs across the NHS.

The NHS is the most culturally and ethnically diverse organisation in the world.[6] Cultural differences may curtail responsiveness of NHS staff and management.[6] The NHS Constitution[7] pledges to provide a positive working environment and promote supportive open cultures that help staff do their job to the best of their ability. Factors that influence the likelihood of staff speaking up, to be able to address current deficits impacting on both staff health and well-being and patient safety,[1 5 8–11] need to be recognised.

It is evident from the literature on speaking up about traditional and professionalism-related patient safety threats that further study on implementation and effectiveness of local FTSUGs and the National Guardian is needed.[6] The extent to which the FTSUGs meet these goals in different NHS trusts is currently unknown. This qualitative study contributes towards a gap in research.

The current literature focuses on organisational culture and leadership as being key to a successful organisation. Organisational culture has been defined as the 'attitudes, values, and norms of members of an organisation'.[12] Schein's definition recognises the hidden aspects of culture, which are the unsaid beliefs held by organisational members and organisational norms,[13] and describes the culture of the organisation in detail. Thus, providing a useful framework to comprehensively assess the culture of healthcare organisations in the context of 'speaking up'.

METHODS

During 2018, the perceptions of the FTSUG and CCs were explored to understand whether recommendations from the NGO[2] had been met by a large NHS trust in supporting staff to raise concerns. Research was based within a large acute hospital NHS trust in England, employing over 20 000 staff. This study aimed to explore by way of a small-scale focus group, perspectives, shared experiences and stories of the appointed FTSUG and CCs working in these roles in addition to their 'everyday' job.

This qualitative study used narrative accounts based on data gathered from a focus group where participants shared experiences while being prompted using a semi-structured questionnaire. Criterion sampling strategy was adapted to ensure that the participant sample matched pre-prepared criteria for inclusion of participants. Since the study was confined to one trust, 21 potential CCs and one FTSUG from this trust were invited by email, all were purposively selected and approached by the researcher. The FTSUG and seven CCs responded and confirmed attendance to the focus group. Each participant was offered an opportunity to ask questions prior to attending

Box 1 Recommendations from the National Guardian's Office (2018) 20 principles[2]

- ⇒ **Culture of safety:** Every organisation involved in providing National Health Service (NHS) healthcare should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
- ⇒ **Culture of raising concerns:** Raising concerns should be part of the normal routine business of any well-led NHS organisation.
- ⇒ **Culture free from bullying:** Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
- ⇒ **Culture of valuing staff:** Employers should show that they value staff that raise concerns and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
- ⇒ **Culture of reflective practice:** There should be opportunities for all staff to engage in regular reflection of concerns in their work.
- ⇒ **Culture of visible leadership:** All employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.
- ⇒ **Investigations:** When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
- ⇒ **Mediation and dispute resolution:** Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff that have raised concerns.
- ⇒ **Training:** Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
- ⇒ **Support:** All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff that raise concerns with ready access to mentoring, advocacy, advice and counselling.
- ⇒ **Support to find alternative employment in the NHS:** Where an NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
- ⇒ **Transparency:** All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
- ⇒ **Accountability:** Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
- ⇒ **External review:** There should be an independent national officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report.
- ⇒ **Accountability:** Everyone should expect to be held accountable for adopting fair, honest and ordinated regulatory action. There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.
- ⇒ **Recognition of organisations:** Care Quality Commission (CQC) should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
- ⇒ **Raising and reporting concerns:** All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Continued

Box 1 Continued

⇒ **Students and trainees:** All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
⇒ **Primary care:** All principles in this report should apply with necessary adaptations in primary care.
⇒ **Legal protection** should be enhanced.

the focus group. Written consent was received at the outset. The time from email approach to the focus group and consent was 8 weeks. Job roles include an intensivist, matron and senior nurses, medics and administration staff. Data were collated, organised and managed via a created table to look across and within each theme. Thematic analysis was undertaken to group data under core themes.

The research questions, topic guide and data collection were informed by themes derived from the literature. Four core themes were apparent throughout the literature search with an emphasis on the origins of 'Speaking Up' with a focus on organisational culture, leadership, barriers to speaking up and patient safety[1 5 6 8–11] (box 2). Project governance and oversight were provided through the primary author's supervisor.

Data collection and analysis

Data were collated via audio recording during the focus group discussion, which were then transcribed by the researcher to identify keywords used by participants. Saturation was reached through the course of interviewing, the researcher noticing the same themes were being repeated within this single-study sample group and were then grouped under headings and subheadings. An inductive approach was used for this qualitative study, as this method of reasoning helps derive general principles and involves the search for patterns to support development of explanations, through a series of generating hypothesis.[14] The phenomenological approach is recognised, as reliance is solely on first-hand experiences of the participants and cannot be generalised. However, this approach can provide a foundation for further studies in other trusts.

Box 2 Focus group guide research questions

Initial introductory and settling in questions
⇒ 'Developing the NHS as A Reflective Learning Organisation', what does this statement mean to you?
⇒ Why did you choose or how did you become a Freedom To Speak Up Guardian and/or Confidential Contact?

Subject research questions
⇒ What is your understanding on the origins of 'Speaking Up'?
⇒ What impact, if any, does the 'Culture and Leadership' within an organisation have on staff's ability to speak up?
⇒ From your experience, what barriers have or would prevent employees from speaking up or raising concerns?
⇒ If so, how do these barriers impact on 'Patient Safety'?
⇒ Provide group discussion points on your awareness of the protection afforded by the Public Interest Disclosure Act 1998.[19]
⇒ What are the anticipated effects the Freedom To Speak Up Guardian and Confidential Contacts system intends to provide for *name of National Health Service (NHS) organisation?
⇒ How can the organisation support these?

Summarising or concluding question
⇒ If you could prioritise one thing that the organisation could do to support you in your Freedom To Speak Up Guardian or Confidential Contact role, what would it be?

Patient and public involvement

Patient and public involvement was sought during the initial design phase of the study with the Clinical Research Ambassador Group (CRAG) at Heartlands Hospital, University Hospitals Birmingham, UK. Discussions with CRAG assisted in the development of the research question, study focus, aims, objectives and outcome measures. Represented by both patients and staff within the group, with an aim to prioritise patient safety, and to address organisational culture and staff well-being. Using experience, preferences and NHS Staff Survey[15] findings to support moving forward towards 'developing a reflective learning organisation' (online supplemental file 1)[16] on speaking up for patient safety and staff well-being. Patients were not involved in this study. Results will be disseminated via a presentation to study participants in the FTSUG and CC quarterly meetings.

FINDINGS

Experiences shared by the participants demonstrate why many of these individuals are working as the FTSUG and/or a CC. The group participants considered, discussed, explored and shared views, knowledge and opinions on the importance of 'speaking up' roles and demonstrated a passion for the subject through tone, expression, engagement and commitment. Themes emerged from the study:

- Origins of speaking up.
- Organisational culture and leadership.
- Barriers to speaking up.
- Patient safety.

Findings suggest there have been negative outcomes in the past within the NHS for speaking up. Group participants detailed their experiences of 'speaking up' and/or of other members of staff 'speaking up'. Followed by the subsequent behaviours they have encountered, as a result of speaking up themselves or through listening and facilitating speaking up of other staff members. Participants discussed their understanding of the origins and importance of speaking up:

> Historically where speaking up came from, there are several high-profile cases. (Participant 2)
>
> Positive or negative impact from culture and leadership. (Participant 2)

> Mid-Staffs Sir Robert Francis report, Speaking Up rather than whistle blowing as no longer a favoured term, captured current structures of Freedom. (Participant 3)

Links between several high-profile cases were referred to, naming investigations, such as Cardiac Services at Alder Hey Children's Hospital in Liverpool, England.[17] The discussion focused on the Francis Report[5] as being pivotal in raising awareness on speaking up. The FTSUG summarised concerns raised from the report and its recommendations.[1 2] They recognised challenges for healthcare staff in being able to safely raise concerns through proper channels and the impact of leadership behaviours on their own and staff members' experiences. Through discussion, reflecting on positive and/or negative leadership experiences, being witnessed or shared by other employees in the clinical setting. Influencing staff ability to speak up, therefore, potentially having an impact on standards of patient care, for fear of reprisal on raising concerns.

Participants were knowledgeable about recommendations from the 2015 Freedom to Speak Up Independent Review.

Participants 2 and 3 provided detailed accounts on findings from the Francis Report and other high-profile cases[1 5 17] and captured current structures of FTSUG.

Barriers to speaking up typically related to experiences shared within the group concerning interdepartmental concerns around culture, context, reactions and behaviour of others. Staff felt victimised and ostracised by senior management and other staff members preventing others in the team to raise further concerns.

> Fear of speaking up myself and for the other staff, for fear of repercussions. (Participant 7)

> Cultural backgrounds and discrimination. (Participant 8)

> Appalling behaviours from senior people, juniors felt threatened. (Participant 2)

Other issues around cultural backgrounds, discrimination and senior staff were raised, namely exploring impact of historical events, and providing detailed examples of more recently raised concerns and the effect to patients and staff.

The FTSUG and CCs elaborated on their roles with passion focusing on staff being able to raise concerns without fear or detriment. Protecting patient safety, quality of care and improving and promoting learning ensured that barriers to speaking up were addressed.

A positive marker of 'change and improvement' was demonstrated throughout the discussion. The FTSUG and CCs provided examples of where strong leadership and visibility had a positive impact on clinical and non-clinical areas, while improvements included a culture of reflective learning from mistakes. The group reflected hypothetically on the difference that strong leadership makes and what this looks and feels like to individuals and to the organisation:

> Visibility as a leader within the organisation. (Participant 5)

> Duty of Candour, learning from our mistakes, and a positive culture. (Participant 8)

The group emphasised that colleagues had previously felt unsupported in raising concerns and shared their own accounts of victimisation and discrimination.

The FTSUG and CCs shared that 'Learning from Excellence' initiative[18] promoted positive culture of speaking up and sought to improve patient care and well-being at local and national levels.

> Making yourself vulnerable, its human existence you will fail, and how do we handle failure, we need to be a reflective learning organisation. (Participant 3)

> Incidents occurred, my reason for reporting was more selfish by looking after myself and my colleagues, it felt out of my control and was upsetting. (Participant 6)

Vulnerability experienced by employees who report incidents or raise concerns, and a fear of failure by healthcare staff in not being able to deliver high standards of safe patient care, impact on individuals and generate emotional deliberations. Reporting incidents for more 'selfish' reasons demonstrates how challenged and stretched healthcare staff feel, as they need to 'look after themselves' to protect and survive working conditions in clinical environments. Feelings of a 'lack of control' and 'upset' in managing busy, stressful situations were key responses that had not been anticipated. These illuminating responses were captured depicting potential and actual example scenarios affecting an individual's health and well-being and safety concerns.

DISCUSSION

The major findings were organised into core themes, namely origins and barriers to speaking up; organisational culture and leadership; and patient safety and staff well-being. The qualitative data generated through the focus group discussion link closely with the existing literature providing four overarching themes (table 1).

Origins and barriers to speaking up

Legal protection from the Public Interest Disclosure Act 1998 is in place to support employees and states that 'A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure'.[19]

Legislation from The Equality Act 2010[20] acts to protect individuals from discrimination. Racial discrimination, whether direct or indirect, is unlawful in the UK and recent high-profile cases have raised awareness and challenged racism in varying contexts.[21]

Table 1 Themes, abstracted themes and participant example quotes

Themes overarching the study findings	**Themes overarching the study findings:** *Origins of speaking up, Organisational culture and leadership, Barriers to speaking up, Patient safety*		
Study areas related to research questions and propositions	Freedom To Speak Up Guardian and Confidential Contact role in an NHS trust Reflective learning organisation Patient safety and quality		
Abstracted themes within the research areas	Powerful personal stories Sharing personal journey Raising own concerns Treatment of themselves and others	Moving forward: reflective learning organisation Positive steps for change and improvement Learn from past mistakes Subsequent detrimental behaviours	Local and national levels Speaking up Culture of blame Bullying, harassment, victimisation Transparency
Origins of speaking up: example quotes from focus group responses	*'Historically where speaking up came from, there are several high-profile cases – Liverpool, Alder Hey, Cardiac Services. Positive or negative impact from culture & leadership.'* (Participant 2)	'*Mid-Staffs Robert Francis, speaking up instead of whistleblowing, captured current structures of Freedom.'* (Participant 3)	
Barriers to speaking up: example quotes from focus group responses	*'Appalling behaviors from senior people, juniors felt threatened.'* (Participant 2)	*'Fear of speaking up myself and for other staff, fear of repercussions.'* (Participant 7)	*'Cultural backgrounds and discrimination.'* (Participant 8)
Patient safety, staff engagement, staff health and well-being: example quotes from focus group responses	*'Making yourself vulnerable, human existence you will fail, and how do we handle failure, need to be a reflective learning organisation.'* (Participant 3)	'*Time, roles, prioritise.'* (Participant 4)	*'Incident, reason more selfish, colleagues, out of my control, upsetting.'* (Participant 6)

NHS, National Health Service.

In 2018, an NGO case review was undertaken at an NHS trust, the report recognised a '*failure of the Trust to meet its responsibilities regarding equality and diversity resulting in Black and Minority Ethnic [BAME] staff not feeling free to speak up*'.[22] The review found that the '*culture, policies and procedures of the Trust did not always support workers to speak up, including evidence of a bullying culture*'. Only one in five staff in the workplace report racism to human resources, fearing repercussions and this being the main barrier to speaking up.[23] Findings from the Francis Report, the NHS Staff Survey and disciplinary Workforce Race Equality Standard data indicate there is clearly a risk that BAME staff may be vulnerable to disadvantageous treatment for speaking up.[1 15 24 25]

Speaking up may take many forms, including a discussion with a line manager, an idea for improvement submitted as part of a suggestion scheme, raising a concern on policy and procedures, bullying, victimisation, equality, and diversity with a FTSUG, or bringing a matter to the attention of a regulator.[26]

Local processes followed at a large NHS foundation trust by the FTSUG and CCs are that some individual cases are discussed confidentially within the quarterly group meetings to keep updated, share learning and seek support on any challenging staff contact cases. Raising current issues, incidents and case reports experienced locally at the trust and nationally through shared learning, this being an important part of their role.

High-profile failures in healthcare always involve some form of inhibiting, preventing or suppressing staff who wished to 'speak up'. Whistleblowers are seen as troublemakers and opportunities for organisational reflective learning are continually missed.

National data gathered from NHS trusts identify source and typology of concerns raised between 2020 and 2021

Box 3 Data gathered from the National Health Service (NHS) trust identify source and typology of concerns raised in 2020–2021[26]

- ⇒ 117 contacts (0.5%) with 101 issues, a contact is defined as each individual, of which 60% (61) were behavioural.
- ⇒ 51 contacts reported experiences of disrespect and/or bullying.
- ⇒ 10 contacts raised allegations of discrimination.
- ⇒ 25% of staff concerns referred to aspects of employment, redeployment or performance and disciplinary matters.
- ⇒ 10% of staff concerns were associated with patient safety.
- ⇒ 5% of staff concerns were associated with health and safety (personal protective equipment (PPE), exposure to infection).
- ⇒ 1 contact was anonymous.
- ⇒ 47.8% of staff within the trust that raised concerns were doctors, compared with 6% of doctors nationally in England, data source 2019–2020, and 13.6% of nurses, in comparison to 28% nationally in England.

(box 3). There should be visible action on detriment for speaking up, wherever this is reported.[27]

Organisational culture and leadership

Leadership is instrumental in any cultural transformation and inadequate leadership has been identified as a key factor when attempts to change culture fail.[28]

Two main styles of leadership 'transactional' and 'transformational' are widely recognised and integration of these two styles is necessary but can be a challenging project.[29]

FTSUGs do not work in isolation as leaders set the tone for a healthy speak up, listen up, follow-up culture.[27] In 2020, 80% of FTSUGs who responded to a survey said senior leaders supported workers to speak up. But in 2021, this fell to 71%.[27] Calls for culture change draw on an acceptance that culture is related to organisational performance and effectiveness across a range of sectors including healthcare.[28 30–32] The patient being at the heart of it all, with teams prioritising goals and helping service providers understand the patient experience. Successful change of the status quo is highly dependent on effective leadership.[33 34]

Patient safety is part of this and the traditional approach to safety focuses on investigating adverse events or near misses, so learning from events can occur and systems put in place to prevent reoccurrence. A new concept in safety is looking at events that go right, to recognise and appreciate this good work. Excellent events could be as complex as a good outcome for a complicated patient in a challenging situation, a member of staff who goes above and beyond what is expected of them or an episode of exceptional team working.[35] Recent results from the NGO annual survey of FTSUGs 2020[36] suggest that things are improving but results are varied across organisations supported by the FTSUGs. Challenges are still being experienced by some employees in being able to create a culture of respect.[37]

The Mid Staffordshire NHS Foundation Trust provided 290 recommendations on care standards, the need for openness, transparency and candour, public access to accurate information, stronger patient involvement and cultural change.[1] An estimated 1200 patients died because of poor care between January 2005 and March 2009. The intention of the duty of candour legislation is to ensure that providers are open and transparent with people who use services.[9 38]

Patient safety and staff well-being

Dysfunctional behaviours and fear of speaking up exist to some degree in most organisations and by not raising concerns patient harm occurs. FTSUGs were recommended for organisations to support workers to speak up when they feel that they are unable to in other ways. Speaking up about anything that gets in the way of doing a respectable job and being able to access an independent person to whom staff can raise concerns without fear of reprisal. Data gathered from the NHS Staff Survey 2019[39] provide evidence of detrimental consequences for staff employees, driven by a lack of strong leadership in the organisation (box 4).

There is evidence of improvement, as various staff groups have contacted the FTSUG or CCs for support and guidance; this has been shared with the trust board but there is still a way to go to address barriers to speaking up, which the literature supports.[1 8 11 40–42]

Studies of safe organisations reveal certain common cultural characteristics: shared core values of transparency, accountability and mutual respect.[1] In these organisations, safety is an organisational priority shared by all. Safe organisations are 'learning organisations' that build shared visions, use systems thinking and respond to untoward events as opportunities for improvement rather than denial and cover-up.

Staff well-being impacts on the ability to empathise with patients, and both staff and patients need care, compassion and respect.[43] In the best trusts, nurses were consulted about change and listened to on care concerns and solutions. In these settings, managers gained insight and understanding from experienced, skilled and motivated staff.[43]

Implications for practice

It is evident that the service provided by the FTSUG and CCs at the trust has meaning and purpose, and the group displays passion and commitment to their roles. Findings link to prior literature which show the impact of disrespectful behaviours on staff performance,[1 40–42] investigations into management, standards and outcomes of care[5 10 17 40 42 44–46] and the impact the FTSUG has in the NHS and independent sector organisations, national bodies and elsewhere.[2] Disrespectful behaviours from the patient directly or from the patient's family can reduce staff adherence to protocols (such as hand hygiene and medication) and impair capacity for effective reflection and communication.[47] Disrespectful behaviours between

Box 4 Consequences highlighted by National Health Service (NHS) Staff Survey 2019[39]

- ⇒ 52% of staff did not feel valued by the organisation.
- ⇒ 48% did not feel involved in decisions that affect their work.
- ⇒ 40% did not generally look forward to going to work.
- ⇒ 40% considered that their organisation would not treat staff fairly in the event of an error or incident.
- ⇒ 12.3% had experienced bullying by managers.
- ⇒ 7.7% had experienced discrimination from managers or colleagues.

staff increase diagnostic errors, reduce information sharing and help-seeking behaviours[48] and can impair elements of team working which can affect both technical and non-technical skills.[49]

An investigation was undertaken into the management, standards and outcomes of care delivered by maternity and neonatal services at an NHS foundation trust between January 2004 and June 2013. The investigation found 20 major failures in care from 2004 to 2013 and made 44 recommendations for both the trust and wider NHS.[44] Further failures were reported from another hospital and were published in June 2018,[45] where at least 450 patients were thought to have died after the administration of inappropriately high doses of opioids between 1988 and 2000. A more recent review of incidents on maternity wards at an NHS trust has identified 1170 cases that warrant investigation. The review reported serious outcomes and failings affecting mothers and babies.[46] It could be argued that healthcare is not moving forward if incidents and issues raised are inherent, and raises the question as to what extent the FTSUGs and Speaking Up Champions and CCs are effective.

Data from the NGO for 'Speaking Up' show there are now an estimated 700 FTSUGs in the NHS and independent sector organisations, national bodies and elsewhere[2]; appointed in hospital trusts, community services, primary care, clinical commissioning groups (CCG), CQC and NHSE. An overwhelming 20 388 cases were raised during 2020–2021, a 32% increase each year since 2017. Nurses raised 28% of cases and behaviours; bullying and harassment were cited in 36% of reported cases from all staff groups; patient safety and quality of care account for 23% of cases. In NHS trusts, between April 2017 and March 2020, 35 530 concerns have been raised with Guardians over a 3-year period.

Further study and data findings from the NGO for Speaking Up are needed to demonstrate to what extent the FTSUGs and CCs are effective. Links to work findings and reports suggest shared individual experiences about patient safety issues and the subsequent behaviours they have encountered continue to have similarities. It could be argued that we are not really moving forward enough if the same issues are inherent and continually need addressing. However, the data support a year-by-year increase into the number of cases raised to the FTSUG service, which suggests that staff are speaking up, wanting to be listened to and heard and moving towards change and improvement. Positively, many Guardians who responded to a recent survey thought that speaking up culture has improved in the healthcare sector (72.8%) and in the organisations they support (74.3%) in the last 12 months. Yet, there has been a fall in the number of respondents who said their organisation had a positive speaking up culture, a decrease of 5% from 2020 (to 62.8%).[27]

Limitations

As this study was a piece of MSc student work, time restraints dictated that only one focus group study at one NHS trust was permitted. Therefore, findings from this preliminary study are limited and cannot be generalised. However, this paves the way for future research as it generates a topic into the public domain and opens a doorway to a new debate with a focus on the FTSUGs and CCs themselves. The researcher is knowledgeable in the subject area and was known to participants. This helped put participants at ease in case sensitive information was shared. To avoid bias and reflecting on future improvements, an independent gatekeeper could limit any coercion.

Studies have shown that focus group mechanisms for securing views highlight some limitations[50] which can inhibit conversation, cause 'group think' and encourage vocal members to oppress less vocal members' opinions and so therefore are not used. Several participants within the focus group were more vocal and expressive on subject areas that mattered to them and spoke in great length and detail. Others were less vocal and participant 1 did not contribute to the discussion other than their initial introduction to the group, despite being given an opportunity by the researcher. This may have been because they did not feel able to or chose not to share their own individual experiences. They did, however, appear to be engaged by actively listening and making acknowledging sounds throughout the discussion.

CONCLUSION

Creating a culture of respect in healthcare is part of the larger challenge of creating a culture of safety. They achieve high levels of mutual trust, collaboration and accountability, both personal and institutional.[8 19] This study has drawn on academic research and documentary evidence in consideration of raising concerns, speaking up, whistleblowing and related concepts associated in healthcare settings. To address gaps in research, consideration is given as to how the FTSUG and CCs view the introduction, development and implementation of these relatively new roles and responsibilities, and how they can play a part in making a difference to NHS employees, patients and carers. The insights that FTSUGs bring are so important in helping us to understand the behaviours and culture that workers experience. These insights can

highlight challenges and function as an early warning system of where failings might occur.[27]

Shared individual experiences from the participants are powerful in demonstrating their own journeys, for some having raised concerns themselves, or witnessed other staff members 'speaking up' about patient safety issues and the subsequent behaviours they have then encountered. This study has been able to highlight the valuable role the FTSUGs and CCs have within NHS trusts and other organisations. Highlighting differences between NHS trust recommendations in England and the requirements in Scotland. Recognising where some NHS Scottish boards outsource independent CCs to the role in an effort to avoid conflict of interests and bias within the organisations. This study also acknowledges how important it is to these individuals, the FTSUG and CCs, to be able to provide this service, and with that in mind they should be applauded and encouraged. This research aims to advance understanding of these roles and raise the profile of the FTSUG service, in support of all NHS employees to feel safe to raise concerns.

Recommendations

The study has been able to identify some fundamental goals and recommendations from the qualitative data:

- NHS trusts, community services, primary care, CCGs, CQC and NHSE are supportive of the 20 principles set out by the NGO, which the FTSUG and CCs are currently putting into practice and/or are working towards putting into practice.
- Evidence to demonstrate that this network of paid employees is meeting these recommendations, acting in an additional role or capacity, should be sought.
- To justify the time commitment and dedication of these individuals, the financial implications of this service and the potential impact of safety for service users within this large NHS organisation.
- Support is available for the FTSUG and CCs to ensure their own health and well-being from their own shared experiences and in supporting others to 'Speak Up'.
- Senior leaders should deepen their support for speaking up, take action to demonstrate safe learning from speaking up and the organisation should support all matters related to speaking up.
- Leaders and managers at all levels should be proactive in encouraging reflective practice meetings, encouraging a culture of raising concerns into normal routine business.

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ORCID iD

Rebecca Delpino http://orcid.org/0000-0001-8465-4279

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