Freedom to Speak Up **Review - HW contribution November 2014**

Preface

This document contains the text of my November 2014 online contribution to the NHS *Freedom To Speak Up* review (http://freedomtospeakup.org.uk/).

Revisiting this some six years later I am struck by how little appears to have changed since then as regards the safety of NHS staff to speak up, as judged by numerous reports in the public domain. I am far from the only one who believes that a different approach to this issue is long overdue.

Updating my 2014 contribution, shown below, newly-appointed managers in a new corporate management structure which was introduced in 2013 in the NHS trust where I had been Director of Medical Physics / Radiation Protection Adviser since 2004 contrived an employment dispute resulting in my dismissal in 2015. An employment tribunal confirmed that I had been unfairly dismissed, and moreover that concerns I had raised in the course of doing my job constituted protected disclosures under legislation which in theory, if not in practice, is supposed to protect employees who raise concerns in the public interest. It is widely acknowledged that this legislation is weak and ineffective - several bills currently going through parliament or under development address its many shortcomings. There is much more I could say about my case, but in brief:

- An external review in December 2014 corroborated my concerns, and found that the department which I led was held in high regard by other hospital departments using radiation (Radiology, Oncology, Cardiology, Nuclear Medicine, Breast Screening, Orthopaedics, Plastic Surgery …);
- An inspection by the Care Quality Commission (CQC) after my unfair dismissal also validated the concerns I had raised. They required the trust to make improvement in a number of areas, including - as I had repeatedly advocated - urgent improvement of medical physics staffing levels and provision of a proper system for auditing and optimising radiation doses to patients from diagnostic x-rays;
- Having previously hollowed-out and de-stabilised the medical physics department, creating a recruitment-retention crisis and inadequate staffing levels exacerbated further by my unfair dismissal, trust managers have now - after a critical CQC report which I explicitly warned would ensue - appointed sufficient numbers of physics staff with salaries uprated in line with national levels;
- Following my dismissal I self-referred to my professional regulator, the *Health and Care Professions Council* (HCPC), as required by its code of conduct. After investigation the HCPC closed the file, confirming that they had no concerns about my fitness to practice;
- Similarly the *Institute of Physics and Engineering in Medicine* (IPEM) undertook an investigation and found that I had no case to answer;
- I believe that newly-appointed managers in a new corporate senior management structure introduced in 2013 were seeking to usurp heads of department roles, and resorted to unfair means to enforce my departure after earlier bullying attempts to encourage me to move on had not achieved this end.
- In addition to my head of department role I was the trust's lead subject matter expert in radiation safety. However, managers appeared to have no compunction in ignoring/downplaying/overruling - and even altering - my expert advice. In this respect I note the identification of *deference to expertise* as a characteristic of high reliability organisations (Weick and Sutcliffe, Managing the unexpected: sustained performance in a complex world, 3rd edition 2015, https://onlinelibrary.wiley.com/doi/pdf/10.1002/9781119175834.fmatter).

Further related work which I have undertaken may be seen at a website kindly hosted by the social enterprise *Care Right Now*: http://www.carerightnow.co.uk/?s=HW+selected+publications.

Hugh Wilkins
January 2021

Please share your experiences of speaking up and raising concerns at work. We are interested in both good and bad experiences.

Introduction

I am finding this a difficult exercise. It is difficult to escalate externally problems which should be sorted out at local level, but I have had bad experiences of raising concerns at work and recognize the need for the 'Freedom to speak up' independent review. I am conscious of the need to separate out concerns about care, malpractice and wrongdoing from a personal grievance dispute. However I believe that the local Trust management response to my raising patient safety-related concerns is influenced by a sad and wearying personal grievance dispute. Moreover I have no doubt that the latter involves malpractice and wrongdoing by my former line manager, who has now left the NHS.

My role

I am a senior clinical scientist, head of a medical physics department in a generally successful medium-sized Foundation Trust providing acute services. The department provides a range of services related to the safe and effective use of radiation for diagnostic, therapeutic and research medical exposures to radiation. I am the Trust's Radiation Protection Adviser, Laser Protection Adviser, Radioactive Waste Adviser and a Medical Physics Expert – qualified expert roles under European and UK legislation. I provide this information purely to set the scene and outline my role – I hope that if the review report refers to my concerns such details would be omitted, for the sake of my future working relationships with current Trust managers.

Staffing levels in my area of work – demand and capacity

The use of radiation in healthcare has increased hugely and become increasingly more complex in recent years, for both diagnostic and therapeutic medical exposures (including CT, interventional radiology/cardiology, advanced radiotherapy, PET and digital radiography). This has greatly increased demands made of medical physicists, who are in very short supply. (There is a national, and indeed international, skills shortage, as shown by Home Office shortage occupation lists.) I have raised a number of concerns over the years regarding staffing levels required to undertake this work to standards expected by regulators such as the Care Quality Commission, Environment Agency, Medicines & Healthcare Products Regulatory Agency and Health & Safety Executive. Despite this I have found it exceedingly difficult to persuade Trust non-clinical managers, who have little understanding of the regulatory requirements in this specialist area, of the need for greater medical physics 'capacity'.

Ongoing efforts to raise concerns have not been helped, in my experience, by upheavals resulting from major changes in the Trust's senior management and administration structures, nor the complexity of resultant management structures. To be fair, there are suggestions that some of my efforts to raise concerns may be beginning to bear fruit, but it is difficult to accept expert advice being dismissed or trivialised by staff newly in post who do not seem to understand the significance of concerns raised. I feel it is wrong that my former line manager, in conjunction with the then Head of Governance, was able to change reports I had written as Radiation Protection Adviser to the Trust, downplaying my concerns at medical physics staffing levels.

Radiation risks to patients and staff

Radiation is a weak carcinogen, and can cause other deleterious tissue reactions. The risks to people exposed to radiation, patients and staff, depend on the dose they receive, the type of radiation, the pattern of exposure, the anatomical areas irradiated, their age and sex. There is legitimate scientific debate over some of the details but nevertheless there is broad scientific

consensus, expressed through authoritative bodies such as the International Commission on Radiological Protection (ICRP) as to the nature and level of these risks. Furthermore there is evidence of radiation over-exposure harming patients and staff, leading to damage such as skin burns, severe ulceration, epilation and cataracts, as well as increased risk of cancer.

It is important to keep doses arising from medical exposures to radiation as low as reasonably practicable to minimise such risks. This is particularly important for relatively high dose procedures and exposures of people particularly susceptible to radiation effects, including children and pregnant women. A comprehensive science-based system of radiation protection in healthcare has evolved over many years, driven by healthcare professionals with expert knowledge in this field, in line with international best practice.

Radiation risks in a wider context

Tissue reactions (sometimes known as deterministic effects) range from mild (such as erythema, with no long term consequences) to major (e.g. skin blistering, tissue necrosis, infertility). In extremis the acute radiation syndrome can be lethal, causing death in a matter of days or weeks. In normal practice tissue reactions should never result from diagnostic medical exposures to radiation. (The only exception to this is that, very rarely, doses from life-saving interventional radiological procedures might be sufficiently high to cause skin effects. Such risks should be identified during consent procedures for interventional radiology/cardiology.)

Concerns have also been expressed over hereditary effects to future generations arising from genetic changes caused by parental exposure to radiation (radiation mutagenesis). The influential United Nations UNSCEAR Committee has reported[1] that *"experimental studies in plants and animals have clearly demonstrated that radiation can induce hereditary effects. Humans are unlikely to be an exception in that regard"*. The Committee notes that *"radiation exposure has never been demonstrated to cause hereditary effects in human populations"*. Ethical considerations clearly prohibit experimental studies. Observational studies of, in particular, the children of survivors of the Japanese atomic bombs have not shown any evidence of hereditary effects. UNSCEAR's interpretation of the scientific evidence is that *"moderate acute radiation exposures of even a relatively large human population must have little impact"*, and that hereditary risk is *"less than one tenth of the risk of fatal carcinogenesis following irradiation"*.

Radiation-induced carcinogenesis is the main risk arising from medical exposures to radiation. Although the risk to individual patients is low, with approximately 50 million medical and dental X-ray examinations carried out each year in the UK[2], and substantially increased use of relatively high dose procedures such as CT, risks to the population cannot be ignored. (Worldwide, approximately 3.6 billion diagnostic radiology X-ray examinations are performed each year[3], i.e. about 10 million per day).

Difficulties in understanding radiation risk concepts

Radiation-induced cancer risks are stochastic, which means that they are probabilistic. Whilst it is possible to estimate risks if sufficient information about the exposure is known, it is not possible to say that a particular cancer has been caused by radiation. Radiation-induced cancer is indistinguishable from the many cancers resulting from other causes. Furthermore there is a

[1] Report of the United Nations Scientific Committee on the Effects of Atomic Radiation to the General Assembly, p.1. http://www.unscear.org/docs/reports/2001/reportga.pdf

[2] Frequency and Collective Dose for Medical and Dental X-ray Examinations in the UK, 2008. https://www.gov.uk/government/publications/medical-and-dental-x-rays-frequency-and-collective-doses-in-the-uk

[3] Sources and effects of ionizing radiation. United Nations Scientific Committee on the Effects of Atomic Radiation. UNSCEAR 2008 Report to the General Assembly. with Scientific Annexes. VOLUME I, p.25. http://www.unscear.org/docs/reports/2008/09-86753_Report_2008_Annex_A.pdf

lengthy latent period, years or decades, between radiation exposure and resultant radiation-induced malignancy. It is unlikely that staff involved in medical exposures will ever knowingly manage patients who have developed cancers resulting from medical exposures which they initiated. Nevertheless there is increasing epidemiological evidence indicating association between medical exposures to radiation and an increased risk of cancer.

Radiation legislative requirements

The Ionising Radiation (Medical Exposure) Regulations (IRMER) protect patients in the UK receiving medical exposures to radiation. Other legislation exists to protect comforters & carers, occupationally-exposed staff and members of the public. There is a legal requirement that doses be kept as low as reasonably practicable.

Managerial resistance to warnings about radiation doses and evidence from dose audits

Few non-clinical managers in my experience have knowledge, skills and experience in such matters, or a training which helps provide an appreciation of statistics or scientific uncertainty. Without this it can be difficult to understand the nature of concerns related to medical exposures to radiation. This is perhaps particularly the case with diagnostic x-rays, because they are so commonplace and have generally obvious benefits. It is however important to ensure that x-ray examinations are properly justified to ensure that the expected benefits outweigh the potential for harm, and that they are optimised to ensure that doses are kept as low as reasonably practicable.

Without wishing to exaggerate risks I have raised concerns, with various levels of local Trust management, that evidence from local dose audits shows that some doses are above relevant benchmarks, and are not as low as reasonably achievable. I have received responses along the lines of *"So what?"* and *"But we are not seeing any evidence of patient harm"*. It is disheartening that managers have ignored the evidence I have carefully provided to them, spurned offers to meet to discuss and silenced me on several occasions when I have attempted to raise such concerns at relevant meetings. In addition to raising such concerns I have identified innovative relatively low-cost solutions.

As friends and colleagues have said, what is the point of the Trust appointing qualified experts in the field, as they are legally required to do, if their advice and professional judgement can be so readily dismissed by managers with positional power, but little true understanding of the issues?

Insufficient response following CQC inspection

The CQC is responsible for enforcing IRMER and conducts occasional specialist inspections to check compliance. Prior to one such inspection I had told my line manager of my concerns in some parts of the Trust and the need, in my opinion, for additional medical physics staff, particularly to support IRMER compliance in departments using diagnostic x-rays. I was not at all surprised that the ensuing CQC report included recommendations of significant improvements required.

Implementation of some of these recommendations requires additional resources. My attempts to secure such additional resources have met with a response from Trust management along the lines of *"If the CQC were bothered about this they would have been back to check that their recommendations had been implemented"*. Knowing how few IRMER inspectors there are, covering all the many healthcare providers throughout the country of services involving medical exposures to radiation, I am not surprised they have not been back to check – their expectation is that the recommendations they made will have been implemented. In warning Trust management that the CQC would, to put it mildly, take a dim view as to the lack of response to their recommendations I have been told I have exaggerated the risk of the CQC issuing a critical report. I have found it

exasperating to find extracts of my own work being quoted, out of context, by a manager unaware that it is my work, to downplay risks which I have identified. Arguably I should have reported my concerns to the CQC, but have been inhibited by loyalties to the Trust.

Consequences of attempting to resolve flawed grading of clinical scientists in my department

The Agenda for Change (AfC) grading and pay system was intended to harmonise pay scales and career progression arrangements throughout the NHS for all staff apart from doctors, dentists and some senior managers. For staff within my department assimilation of clinical technologists, allied health professionals, nurses and administrative staff to the new pay-scales was relatively straightforward, probably reflecting job panels' familiarity with these staff groups.

There was however a major problem with the bandings of medical physics clinical scientists. Almost all of these posts were initially banded incorrectly, creating major recruitment and retention difficulties, not to mention resentment at the poor quality of the banding process and incalculable effects on morale. It took nearly 8 years, but one by one these grading errors have been resolved apart from for one post, my own. Whilst appreciating the need to separate out personal grievance disputes, I think that my refusal to accept the blatantly flawed process which has resulted in me being demonstrably the lowest paid Head of a Medical Physics Department in the country with responsibility for a range of services including radiotherapy physics has affected the way I am seen by Trust management. This is despite delivering services which, in a difficult financial climate, have regularly attracted commendations.

(To translate this last point into more concrete terms, developments which I have instigated and led have resulted in changing the culture in one service from complaints to commendations, increasing activity by 70% with fewer staff, reducing waiting times from >6 months to 3 weeks without additional resources, achieving 26% CIP (cost improvement programme) savings with minimal adverse effects and generating substantial income. My "reward" for these contributions has been disintegration of my department under a Trust senior management review which has resulted in creation of new layers of management and governance, not to mention five- and six-figure pay-offs for a number of departing managers, including my former line manager.)

As noted in the introduction, I believe that the local Trust management response to my raising patient safety-related concerns has been influenced by my long-running personal grievance dispute. I have compelling evidence that my post was wrongly graded, as a result of gross abuse of the nationally-agreed AfC job evaluation process by my former line manager. This would seem to fall into the category of malpractice or wrongdoing at work. As an indication of how badly the process was undertaken, my line manager refused to accept the banding of a job panel, refused to allow my post to be banded against appropriate national profiles, refused to allow me access to staff job analyst support when having to complete totally unnecessary job assessment questionnaires, blocked requests for consistency checking (a fundamental aspect of any job evaluation scheme) and also (contrary to local and national procedures, not to mention the NHS constitution) blocked a grievance which I submitted - despite the finding of an earlier grievance hearing which had confirmed inconsistency in the banding of my post.

This has been terribly time-consuming and a diversion from the job I came to do, although the bulk of the unnecessary work related to Agenda for Change has been done at weekends and evenings. It has had an inevitable effect on my health and well-being. When I have occasionally expressed anger, at not only the way I have been treated but also the gross abuse of power and poor use of scarce NHS resources, I have been referred to the occupational health service. They pointed out to my line manager the need to resolve this long-standing dispute for the sake of my health. His response was to send them, and my GP, false and misleading information. Occupational health also

referred me to an educational psychologist, explaining to me that this would produce an independent report which they, occupational health, would be able to use to counter damaging allegations by managers against me.

What can happen to people who speak up

Without wishing to blow this up out of proportion, it brings to mind the former Soviet authorities' approach to dissidents who dared to challenge the system, the political abuse of psychiatry. There are also parallels, to an extent, with the unfortunate case of Ignaz Semmelweis, whose pioneering work on the importance of hand hygiene led to his committal to an asylum. Other examples of people whose attempts to improve medical practice were not well received initially include Ernest Codman, who lost his staff privileges after suggesting the evaluation of surgeon competence, and Alice Stewart, whose pioneering identification of the risk of x-rays as a cause of childhood cancer were dismissed by the then establishment. In each of these cases the validity of the concerns which they raised has since been fully accepted, and has led to substantial changes in medical practice, but they were punished in various ways for their audacity in raising legitimate concerns. Their 'crime' was to be ahead of their time.

I appreciate it would be wrong to draw the analogies too far. However, my experience shows that, despite all the talk about need for clinical leadership, staff who raise inconvenient concerns and legitimate challenges can find the NHS system not only unresponsive, but arguably vindictive.

Link between personal grievance dispute and concerns about care

I would like to make the point that, although I have been particularly critical above of an individual, my former line manager, I certainly would not wish to tar all NHS managers with this brush. I appreciate they have a difficult job to do and understand why other managers are unwilling to re-visit the mess which I and others know that he created. Nevertheless I suspect there is irritation within senior management circles that I have not acceded to the local flawed bandings of medical physicists including myself, and that this has negatively affected collective perceptions of the evidence-based radiation-related patient safety concerns that I have raised.

If your experience was positive, what do you think made it successful? If it was not a good experience, what in your view were the main problems?

Power without responsibility

I think the main problems stemmed from a strong emphasis by senior managers on financial aspects, with cost-cutting and asset-stripping being given a much higher priority than concerns raised by healthcare professionals such as myself. Allied to this I believe my former line manager was reckless and strongly motivated by self-interest. He essentially distanced himself from problems created by his actions (such as the resignation of staff to move to equivalent posts at neighbouring Trusts graded considerably higher, in line with the national AfC process). I should mention that he was in charge of the local AfC assimilation process. It appears to be classic power without responsibility.

Shooting the messenger

Although other managers were aware of concerns I have raised, I think there has been an element of groupthink, with me being seen as a troublemaker, and one who can be dealt with by being marginalised. They seem uninterested in original work I have undertaken, directly related to the radiation dose concerns I have raised, which has been published and presented at national and

international meetings. From my position the Trust feels like a very top-down organisation. Despite rhetoric about the importance of innovation, I and other scientific staff have found it extremely hard to obtain funding for relatively low cost innovative improvements.

Organisational structures, accountability and barriers to bottom-up communication

The system is overly bureaucratic, and has become increasingly so in some respects. Astonishingly to many of us providing clinical and clinical support services, more layers of general management have been created in recent years. The staff appointed to these new posts typically have little if any operational experience in areas in which they are now adjudicating. Human nature being what it is, we are now seeing signs of job creation/preservation/protectionism amongst this cadre of middle managers, resulting from an understandable need to justify their existence.

It all seems rather different from the move towards flatter management structures that we hear about as being the way forward. Far from clarifying accountability, the new structures in practice have increased the propensity to pass the buck when difficult issues arise. As the Berwick report notes[4], when responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.

Meanwhile management at the top of the organisation appear to have insulated themselves to a greater extent than ever before from concerns raised by some very experienced healthcare professionals. With all the layers of administration that have been introduced, and lack of specialist knowledge of many of the post-holders occupying these positions, Chinese whispers can lead to serious distortion of messages. Successive staff surveys show very poor communication with senior management within the organisation – exceptionally so in the case of the directorate headed by my former line manager, an epitome of control and command.

(He incidentally took evident pleasure in telling me on my first day in post that (a) he did not want my post to exist, and (b) his post was not only directorate manager but also clinical director – with the latter appointment being permanent, not rotating as was normally the case for clinical director posts. His message was clear. There was an absence of the normal checks and balances within that directorate, now thankfully disbanded.)

Difficulty of proving safety - testing the system to destruction

I have been very disappointed by the response that I have had on more than one occasion from managers that they cannot see any negative effects from concerns I have raised. It is difficult, if not impossible, to 'prove' safety. Conversely it can be difficult to prove that a system is unsafe - until it goes wrong. The logical conclusion of this management approach seems to be a need to test the system to destruction before warnings are heeded. It is all very alien to the proactive/generative culture of my profession as described in a recent publication[5]. The Trust approach by contrast seems more geared towards pathological/reactive/calculative tendencies. I like to think my approach is more consistent with that of Professor Berwick.

Please share your views and ideas on what would help to create an open and honest reporting culture in the NHS.

[4] A promise to learn - a commitment to act. Improving the safety of patients in England, p.8. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[5] IRPA Guiding principles for establishing a radiation protection culture, p.11 (http://www.irpa.net/members/IRPA-Guiding%20Principles%20on%20RP%20Culture%20-2014%20.pdf)

Those raising concerns should have recourse to independent review if not resolved locally

It seems to me that there is a burning need for staff finding themselves in a position such as the one in which I have found myself to have recourse to independent review of serious concerns that they have raised, if such concerns are blocked locally. They should be able to be present in important decision-making meetings, not excluded from closed door discussions affecting them, as sadly has been my experience. I recognize that measures would need to be put in place to discourage escalation of frivolous concerns, though these should not enable legitimate concerns to be side-lined.

Such independent review needs to be genuinely independent, with genuine powers to hold people to account. Any tendency to allow managers to invite adjudication from colleagues/friends, even if from another organisation, should be balanced by an opportunity for 'whistleblowers' to nominate unbiased reviewers.

As noted previously there may be resistance to concerns raised about patient safety because of disputes in other areas which may have caused relationships with managers to have deteriorated. Such disputes can have a terribly corrosive effect, and need to be resolved. This is true even if, particularly if, such disputes are long-standing. The person raising concerns should have access to proper representation. If appropriate, staff should be allowed to have legal representation at hearings affecting them, having had adequate opportunities to brief their representatives beforehand.

I think there is a real need for professional bodies with expert knowledge of the area concerned to be involved if they and the individual raising concerns feel their involvement is warranted. My experience in this respect, is that my professional body, whilst expressing sympathy, has felt unable to engage on my behalf because of its charitable status. I fully recognize the importance of this point. However when issues of patient safety arise, including staffing levels, there should be a strengthened role for peer review and input from professional bodies.

Similarly I think it is right that individuals should have access to advice and support from other sources, as spelt out in the NHS Employers Model process flowchart for raising concerns. The most appropriate sources of advice/support will probably depend on particular circumstances, but I hope that the Review makes very clear that individuals raising concerns are perfectly entitled to access such support at their discretion. Going further, I think this entitlement to advice and support should be explicitly extended to peers and mentors. Those raising concerns should not be penalised for seeking advice and support in confidence from experienced, knowledgeable, responsible third parties. Employers should welcome input from such sources, not see it as a threat.

My employers, like many NHS Trusts, use the Datix risk management system. Whilst I feel that the concept of grading risks is good, my experience is that concerns can be blocked by managers who do not truly understand the issues involved and can grade risks inappropriately, in my opinion. This can result in management above them either being kept in the dark, or over-reacting.

It is difficult to have faith in local whistle-blowing policies – what seems to happen in my experience is that managers almost invariably support previous management decisions. It is difficult to be anything other than cynical in this respect. The need for a system of independent review/resolution of genuine concerns and disputes, by experts with relevant professional knowledge, seems overwhelming.

Any other comments?

Multiple, sometimes conflicting, loyalties

We all have multiple, and sometimes conflicting loyalties, including to our professions, colleagues as well as the organisations which employ us. Transcending these is our responsibility for high quality healthcare for patients. I hope that if the review includes some of the material in this submission it will not be to the detriment of my future working relationships with Trust management. To this aim I reiterate my hope that I would not be readily identifiable, as I am sure I would be seen as having betrayed the Trust, with predictable consequences. Despite this I think these issues are important, and it is important to bear in mind national, as well as more parochial, perspectives. I hope that these contributions to the Freedom to Speak Up review will be helpful.

Too many cooks, too many meetings

I think it is regrettable that the term 'governance', which has only entered the NHS lexicon relatively recently, has in part turned into a process-driven box-ticking industry, stifling innovative clinical leadership. I hope it is not politically incorrect to use the phrase "too many chiefs and not enough indians" – it is a phrase used quite often locally, along with the refrain of "too many meetings". Many healthcare professionals feel strongly that many of the meetings we are required to attend do little good, and that the elaborate management structures that have been put in place, far from acting as conduits, actually act as barriers.

Raising concerns can create 'a rod for your own back'

There is sometimes a feeling amongst experienced healthcare professionals , borne of experience, that it is simply not worthwhile raising concerns, because then the person raising concerns is expected to "own" the problem and solve it, regardless of resource implications. The inevitably-resulting action plans, with often absurdly unrealistic 'deadlines' for completion of tasks, can seem like a rod for your own back. It is effectively "shoot the messenger".

Saliency of the Berwick Report

I hope I would not be exhibiting delusions of grandeur by ending with a reference to the landmark document from the National Advisory Group on the Safety of Patients in England *'A promise to learn – a commitment to act: Improving the safety of patients in England'*. I have indicated some personal opinions which I believe chime with issues raised in that report. I think these relate directly to recommendations 1, 2, 4, 5, 7 and 9 in that report[6]:

1. *The NHS should continually and forever reduce patient harm by embracing wholeheartedly an **ethic of learning***

   ….Where scarcity of resources threatens to compromise safety, all NHS staff should raise concerns to their colleagues and superiors and be welcomed in so doing….

2. *All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place **quality of care in general, and patient safety in particular,** at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support*

   …Constantly and consistently assert the primacy of safely meeting patients' and carers' needs…

[6] A promise to learn - a commitment to act. Improving the safety of patients in England, p.5. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

…Expect and insist upon transparency, welcoming warnings of problems…

…Use data accurately, even where uncomfortable, to support healthcare and continual improvement…

4. *Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future.* ***Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported***

   …Each organisation should be expected to listen to the voice of staff to help monitor the safety and quality of care and variation among units…

   …Be willing to speak up to leaders when you believe that a lack of skills, knowledge or resources places patients at risk of harm…

   …we call managers' and senior leaders' attention to existing research on proper staffing, scientifically grounded evidence on staffing that leaders have a duty to understand and consider…

5. ***Mastery of quality and patient safety sciences and practices*** *should be part of initial preparation and lifelong education of all health care professionals, including managers and executives*

   …The most powerful foundation for advancing patient safety in the NHS lies much more in its potential to be a learning organisation, than in the top down mechanistic imposition of rules, incentives and regulations...

   …NHS-funded health care providers should invest in building capability within their organisations to enable staff to contribute to improvement of the quality and safety of services to patients…

7. ***Transparency should be complete, timely and unequivocal.*** *All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public*

   …Patient safety cannot be improved without active interrogation of information that is generated primarily for learning…

   …aggregated data may camouflage variation within organisations that would be revealed by intelligent fine-grained analysis … Leaders need to seek out variation within their organisations(not just among organisations) if safety and quality are to be effectively monitored and improved...

   …Commissioners should increase funding for NHS organisations to analyse and effectively use safety and quality information…

   …Healthcare organisations should shift away from their reliance on external agencies as the guarantors of safety and quality and toward proactive assessment and accountability on their own part…

9. ***Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility.*** *They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.*

   …Regulation should make clear the expectations that providers must meet, detect failings early, and take appropriate action when sub-standard care is found. The most effective regulation comes from a mixture of principles-based standards (developed by a process involving patients, carers and the public) and technical specifications where appropriate, supported by an inspection regime with true experts who are able to apply thoughtful judgement and the right actions in response…