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Exploring the Influence of Leadership, Culture and Hierarchy on Raising Concerns Relating to Patient Deterioration

Report to NHS England Worry & Concern Steering Group

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Executive Summary

Background: The NHS England and Improvement (NHSE/I) Acute Deterioration Board (ADB) was established to understand and improve the recognition and response to acute deterioration in a range of healthcare settings including learning disability, mental health, care homes, and acute care settings. To understand the barriers and enablers to escalating concern that can affect the care and outcomes for patients, the ADB convened a national "Worry and Concern" Task and Finish Group (WCG). One aspect of the work of the WCG was to explore with clinical staff, patients, their families and/or carers the experiences of raising worries and concerns, and to identify interventions or actions that can be taken to address obstacles. Evidence suggests that working cultures, professional hierarchies, and the nature of leadership in healthcare environments often underpins a reluctance of clinical staff, students, patients, carers and family members to raise concerns over patient deterioration and be heard (O'Neill et al 2021; Iddrisu et al, 2018; Campling et al, 2018; Massey et al, 2017; Guinane et al 2018; Rainey et al 2013). WCG commissioned the Florence Nightingale Foundation (FNF) to undertake a "thought leadership" project to identify these issues and make recommendations for future interventions.

Method: A qualitative study was undertaken to understand clinical staff's, patients, their families and/or carers experiences of raising concerns. The aims of the study were to:

- Undertake an in-depth exploration into the influence of leadership, culture and hierarchy on raising concerns relating to patient deterioration
- Interpret the findings through the lens of person-centred practice underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding
- Make recommendations for policy and practice to enable and enhance person centred cultures of empowerment.

A qualitative descriptive design was chosen with qualitative data collection in seven focus group discussions with a total of 27 participants (n=27) to explore opinions, reflections, meanings, and descriptions about the specific issue of raising worries and concerns. Three audio-recorded vignettes, describing real-life clinical situations aligning to the three themes (leadership, culture, and hierarchy), were selected and obtained for use in the focus group discussions to prompt explorative discussions. A deductive thematic analysis was undertaken of the resulting focus group transcripts.

Findings: The findings highlight elements of the healthcare environment that influence the quality of the care delivered to the patient. Leadership that role models multi-disciplinary team working, values the expertise of all stakeholders, and champions person-centred practice can create a positive working culture. This culture creates an environment in which clinical staff, patients, carers, and family members feel confident and less hesitant in raising worries and concerns. In healthcare environments where these characteristics are not present, staff training and development alongside access to, and the availability of feedback avenues can provide psychologically safe spaces for clinical staff and students to escalate concerns and improve patient safety. Nevertheless, healthcare environments are often characterised by overworking and understaffing which can negatively influence clinical staff and students' ability to deliver person-centred practice.

Recommendations: The study concludes with 11 recommendations summarised below:

1. Provide adequate avenues for feedback
2. Ensure closure of feedback loops
3. Promote and facilitate patient involvement in their own care

4. Provide and promote opportunities for patients, carers, and family members feedback
5. Provide and promote patient safety partner involvement
6. Provide training sessions for all clinical staff, relevant non-clinical staff, and students on detecting and escalating recurrent and major patient deterioration incidents
7. Prioritise staff wellbeing in healthcare environments
8. Empower newly registered staff and students practice
9. Commission further research to explore cultural background influences
10. Commission further research to explore generational differences
11. Commission further research to explore consultants' perspectives.

Background

In 2019, 22.5% of all deaths in the UK were considered avoidable (136,146 deaths out of 604,707) (ONS, 2019). The early recognition and treatment of deterioration in patients is a central aspect of rapid response systems (RRSs). RRS's aim is to reduce intensive care unit admissions, length of stay in hospitals, and mortality rates (Douw et al, 2015). RRS's are often based on the recording of vital signs (e.g., blood pressure, respiratory rate) using tools and measurements that capture physiological signs and provide a score for clinical staff to assess and determine if escalation and/or additional clinical intervention is required. The Early Warning Score (EWS) has been developed to recognise patient physiological deterioration. However, the EWS does not capture clinical staff's intuitive assessment of patient's risk of deterioration.

Clinical staff, often recognise deterioration in patients by using their intuition. In practice, intuition often involves clinical staff expressing worries and concerns based on their own personal judgement or 'gut' feeling rather than through the routine measurement of vital signs (Douw et al, 2015; Romero-Brufau et al, 2019; Massey et al, 2017). Research highlights the role of nurses' intuitive assessment in recognising deterioration (Douw et al, 2015; Romero-Brufau et al, 2019). One reason is that nurses have more consistent direct contact with patients compared to other clinical staff such as doctors, and in turn, are better positioned to detect subtle and/or acute changes earlier and more quickly (Cioffi, 2000). Although intuition is subjective and tacit in nature, intuition could be interpreted as a unique form of valuable knowledge itself. Knowledge that derives from clinical experience, knowledge, skill, and expertise in action. Research highlights that the use of 'objective' measures and/or tools that detect EWS lead to the escalation of care concerns compared to intuitive assessment (Smith et al, 2021). Whilst intuition cannot be easily quantified or measured, it's impact in relation to not only clinical staff but also patients, and their families/carers in recognising patient deterioration cannot be entirely dismissed, and points to the role of wider contributing factors that impact on raising of worries and concerns.

Several factors have been identified which impact on clinical staff raising worries and concerns about the deteriorating patient. Research highlights that the influence of hierarchy and leadership within clinical settings can undermine staff's ability to both recognise patient deterioration and escalate concerns appropriately (O'Neill et al 2021; Iddrisu et al, 2018; Cioffi, 2001). For example, the hierarchal nature of different clinical roles and the levels within and between roles means that there are varying levels of seniority, accountability, and differing duties/tasks depending on specific roles. Multiple studies have highlighted that junior staff have been reprimanded, blamed, and dismissed for escalating care or raising concerns due to their perceived lack of seniority level and/or the action taken is out of their scope (O'Neill et al, 2021; Campling et al, 2018).

The organisational culture can have a significant impact on patient care. Edmondson (1999) describes a need for team psychological safety in organisational cultures, meaning a "shared belief held by members of a team that the team is safe for interpersonal risk-taking" (p.350). Psychological safety involves feeling able to take risks in front of others and building an environment focused on learning rather than blame. Studies emphasise that cultures of fear and blame, which undermine psychological safety, can lead to clinical staff feeling more hesitant in raising worries and concerns out of fear of being belittled, accused, and/or being castigated by colleagues, senior management, and/or the organisation (O'Neill et al 2021; Massey et al, 2017). This contributes to a blame culture arising from a lack of willingness to take accountability (O'Neil, 2021). In addition, a significant proportion of clinical staff have reported bullying,

harassment, and abuse in the workplace (NHS England, 2020). This often leads to clinical staff experiencing negative emotional responses (e.g., anxiety) (Rhead et al, 2020) and can delay the escalation of care concerns (Massey et al (2017).

Different styles of leadership including command-and-control (CAC) have been identified to affect individual's ability in raising worries and concerns. A CAC style is typically authoritative in nature and involves decision-making using a top-down approach style. Whereas a more collaborative leadership style involves more communication and cooperation using a bottom-up approach when decision-making. Research highlights that a collaborative style can facilitate between communication and collaboration amongst clinical staff, patients, their families and/or families or carers compared to CAC (West et al, 2020). Additionally, this style of leadership can increase clinical staff's confidence in responding to patient deterioration whilst also allowing patients to take a more active role in their care (Massey et al, 2017; Guinane et al 2018; Rainey et al 2013). Creating a partnership between all stakeholders involved in a patient's care has been identified as a key factor in encouraging the raising of any potential worries and/or concerns (Guinane et al, 2018; Campling et al, 2018; Cioffi, 2001; McKinney et al, 2020).

Patients, their families and/or carers have been identified as critical in identifying and reporting potential deterioration (Strickland et al, 2019; Guinane et al, 2018). However, clinical staff are often perceived as the 'experts' or 'knowing best' and this can lead to patients taking a more passive role in their care. For example, feeling unable to voice their concerns, not perceiving themselves as an 'expert' in their own care or feeling that their worries are not being heard or acknowledged by clinical staff (McKinney et al, 2020; Guinane et al, 2018; Strickland et al, 2019). A further challenge impacting both clinical staff and patients includes wider workforce challenges and external pressures. These include understaffing, excessive workloads, and inadequate working conditions (West et al, 2020). Several studies have identified that these can significantly impact on clinical staff's ability to build quality relationships with patients which can help support better communication with raising worries and concerns. These wider issues can also impact on the willingness of patients, their families and/or carers to raise concerns over fears of being a 'burden' or 'imposing on already busy staff' (Hope et al, 2022; Rainey et al 2013; McKinney et al 2020; O'Neill et al 2021).

Factors that enable better recognition and response to patient deterioration include clinical staff education and support in the responding and recognising patient deterioration (Massey et al, 2017; O'Neill et al 2021). Access to educational training opportunities allows staff to develop their healthcare practice, increase their knowledge, and further develop skills to better recognise and respond to patient deterioration (Freathy et al, 2019; Massey et al, 2017). Supervision from clinical supervisors, educators, and leaders is important in supporting clinical staff to identify areas of their practice that can be strengthened and developed to deliver better patient care (Massey et al, 2017). In addition, there is a positive relationship between staff wellbeing, patient care outcomes, and experiences of care when clinical staff feel there is a positive organisational culture, increased job satisfaction, and reduced emotional exhaustion (Maben et al 2012).

Person centred practice (PCP) is an approach which places patients, their families and/or carers at the centre of decision-making processes (McCance & McCormack, 2021). PCP involves the forming and fostering of collaborative relationships between all stakeholders involved in the patients care. PCP challenges traditional clinical practices which are often task-oriented in nature such as a focus on system efficiency and the use of medical labels. Traditional clinical practices can lead to patients and their families and/or carers feeling dehumanised, devalued, and ignored in decision-making processes (McCance & McCormack, 2021). PCP is a framework

that explores layers of factors that impact on the delivery of person-centred processes using five categories: (1) macro-context (e.g., policy), (2) pre-requisites (e.g., educational background), (3) care environment (e.g., leadership), (4) person-centred processes (e.g., therapeutic relationships), and (5) outcomes (e.g., length of stay). Whilst patients, their families and/or carers have been identified as integral in reporting and identifying patient deterioration, PCP has not been used to explore raising worries and concerns.

Many studies refer to the influence of culture, leadership, and hierarchy when raising worries and/or concerns. Whilst these studies point to the importance of these factors, there are few studies that overtly focus on these areas in depth, and in particular, their relevance and influence in relation to clinical staff, patients, families, and carers raising worries and concerns regarding patient deterioration. In addition, the importance of including patients, their families and/or carers in healthcare decision-making is consistently highlighted within the literature. However, the mechanisms which enable and impede this have not been considered. The PCP framework offers a theoretical lens to critically consider the reasons why these areas are important and to also identify the potential barriers and enablers in raising worries and concerns (McKinney et al, 2020).

To address this, FNF carried out a research study to explore clinical staffs, patients, their families and/or carers experiences and perceptions of leadership, culture, and hierarchy, and the influence of these, when raising concerns relating to patient deterioration. PCP was chosen to use as an analytical framework to illuminate and reveal different layers of person-centred processes that may impact on raising concerns of patient deterioration. FNF also set out to provide a series of recommendations for the Worry & Concern Task and Finish project.

Methodology

A descriptive design was chosen with qualitative data collection in focus group discussions (FGDs). FGDs was considered the appropriate method as the research question sought to explore opinions, reflections, meanings, and descriptions about the specific issue of raising worries and concerns. Compared to individual interviews, FGDs encourage interactions between participants, and these interactions can bring about richer and deeper knowledge (Krueger, 2014). In FGDs, views can be challenged, opinions can be contradicted, and new insights can emerge through the encouragement and sharing of a range of different viewpoints (Willassen et al., 2018). FGD's can create an environment in which a variety of perspectives can be represented, included, and voiced.

An interview guide was created prior to the FGDs. The interview guide included a range of open-ended questions that related to the themes of (1) leadership, (2) culture, and (3), hierarchy. The guide was piloted and refined with our steering group of subject experts who provided expert external scrutiny, including a patient carer who shaped the patient, family members and carers FGD questions. The interview guide was created to complement the use of vignettes during the FGDs. Three audio-recorded vignettes were selected, and approval was obtained for use in the study. Each vignette described a short story based on a real-life clinical situation that aligned with the three themes of leadership, culture, and hierarchy. Therefore, the vignettes were familiar, plausible, and real for participants. In healthcare research, vignettes allow participants to explore clinical actions in context, define a situation in their own terms (Hughes and Huby, 2004), and disentangle the conflicts and complexities of everyday clinical settings (Rossi, 1979). Critically, in this study, the use of vignettes provided a less personal and less exposing or threatening way of exploring the sensitive topic of raising worries and concerns. The vignettes were played at the start of each FGD and were the stimulus for discussion, participants were then prompted to respond, and their thoughts, reflections, and opinions were elicited using the interview guide.

Ethical approval was granted by the Ethics and Research Governance Online (ERGO) system at University of Southampton (Ethics/IRAS no: 71939). All participants were provided with a participant information sheet and signed an online consent form to be recorded and for de-identified quotes to be used in publications before the FGDs. Full explanation of the purpose of the study and information regarding confidentiality was provided at the start of each FGD. All participants consented to the discussions being recorded. No payments were given to participants and participation was voluntary. A steering group of external subject experts was formed to provide external governance and subject expertise throughout the study.

FGD's were advertised via FNF networks using a mixed recruitment strategy. Seven focus groups were conducted with participants from the United Kingdom, between June and August 2022. Each FGD had a facilitator and a note-taker, all employed by FNF. Each FGD lasted between 75 to 90 minutes. Focus groups were conducted online using an online platform. Online FGD's were the preferred method to increase the recruitment of a wide-range and high number of stakeholders, and to provide more flexibility and accessibility for participation.

Participants (n=27) comprised of clinical staff and students (n=18) and patients, family members, and carers (n=9) either working in health and social care services or have experience of health and social care services in relation to raising worries and concerns. Four of the seven focus groups included clinical staff/students (n=18), and the other three focus groups were attended by patients, family members, and carers (n=9). The clinical staff/student groups consisted of 15 nurses, two allied health professionals (AHPs), and one midwife.

The transcripts were uploaded onto NVivo, and a thematic analysis was undertaken in line with

Braun and Clarke's (2006) six phase guidelines. All transcripts were coded based on a deductive thematic (leadership, culture, and hierarchy) analysis, constructing a thematic map with sub-themes, and reviewing the data underneath each potential sub-theme. The authors revisited the transcripts after creating a thematic map to ensure the themes accurately reflected and represented the data. The themes were then refined and named to produce this study. The initial thematic findings and then the first draft of this study were presented to our steering group for expert external scrutiny.

Findings

Leadership

In this section, findings relating to leadership are outlined. These include, leadership shapes culture, anyone can be a leader, role modelling, accountability, multi-disciplinary teams, and documentation.

Leadership Shapes Culture

15 participants highlighted that leadership sets the tone of the culture and impacts on patient safety. Leaders can either encourage multi-disciplinary working and psychologically safe cultures, or leaders can create a culture of fear and blame. For example, participants discussed the importance of positive leadership shaping a supportive culture:

> *If you nurture your staff and you support them to be able to be open and say 'this is what I think' and not belittle their answers when it might not be right or might not be where actually we were thinking .... But you're giving them the ability to have that voice … they will absolutely then go on and say more. So supportive and nurturing culture and be kind. You know, everyone's a human.* [C16]

Participants also described how leaders with negative attitudes can impact on the cultural norms in the workplace and patient safety. For example, leaders can encourage others to escalate concerns or be dismissive which can impact the willingness of staff to raise a worry or concern.

> *[EWS are] only as good as what the response is on the other end … [when escalation] goes very wrong … it's because at some point someone's made the decision. 'Oh no, it wasn't really like that. Oh, it's OK, that nurse is known to be like that.'* [C18]

One participant described how leaders who encourage others to continue escalating concerns may have changed over time. This change also appears to coincide with a change in organisational culture from one which relies on intuition rather than tools to detect deterioration and activate escalation.

> *When I was a junior nurse on the ward, if I escalated a concern … [and] if that first person hadn't have listened to me, I would have gone to the next person and the next person and the next person. I felt confident within my role that that was accepted … that I knew that the consultant looking after that patient would want me to escalate it … that gave me the confidence to keep challenging and I think maybe that's been lost a little bit … we didn't have … new scores, so a lot of our clinical skill was from that gut feeling and that you knew your patients really well … So I think it again it goes back to the organisational culture but that has changed across the whole of the NHS over time that people obviously feel more intimidated to raise concerns in different ways. … People perhaps not quite as certain of because we've got more tools to help guide us, particularly with patients that are deteriorating, that we're more reliant on that than we used to be before.* [C10]

In the patient and carer/family member group, four participants shared their different first-hand experiences and linked this with leaders who set the tone of culture. For example, one participant described:

> *The quality of interaction with [clinical staff] in my experience varies enormously and therefore the quality of care that I feel I've received varies enormously. In hospital care, what seems to really make the difference is the culture in the team is set by the consultant. And if you have a fantastic consultant leading the team, it impacts on everything, on the way nursing staff, if you're an inpatient, deal with you.* [P/C9]

One carer described positive experiences involving person-centred practice which they observed, and this appeared to stem from a leader who set the culture of that team:

> *Our first meeting with the lead consultant who was a neurologist, he walked into the room and what I find fascinating was that…[he] didn't adopt an arrogant position at all…the entire staff in the unit treat [my child] as a human being. The consultants seem to work with the staff, so cohesion. There's a morality there. There's a value of the person as a person as opposed to just treating their medical condition* [P/C 7]

Anyone Can Be a Leader

Eight participants discussed how anyone can be a leader and that leadership means more than solely one person in charge. One participant described leadership as:

> *Leadership doesn't necessarily have to come from the hierarchy setup, so a leader doesn't have to be a manager or someone at the top, but then they have to have a strength of conviction that what they're doing is right so that they can show those in charge that it's the right thing to be doing.* [C5]

Two participants discussed how all clinical staff, including students, have the responsibility to challenge and speak out against actions that do not reflect best practice. One participant described how it can be difficult to challenge someone higher up in the hierarchy at the time, but recognised that they have a responsibility to speak to another colleague after the event:

> *Because, you know, in modern medicine and surgery, we have something called human factors training and it's all around the hierarchy and we all have a responsibility to say, stop all of us. Because that stop could be saving someone's life* [C18]

Responsibility and ensuring actions are taken was a recurrent theme amongst participants. Three participants described how encouraging and increasing the number of leaders in lower bandings was important. More specifically, two participants described how newly registered staff have the most up to date clinical knowledge and skills and questioned why they are not encouraged to be leaders in the workplace. One participant said,

> *[Senior staff] are not always right. They're not always the ones that are involved …. They're also not the ones that have the most up to date clinical knowledge. Our students and newly qualified staff are so up to where we should be practicing the way our absolute best practice. Why are we not taking that, taking their interests, their expertise forward and being able to let them do that?* [C16]

Another participant described a personal experience of leadership and the confidence to challenge and follow up on concerns, which they believe makes a difference to patient outcomes.

> *I remember a day when I was a ward staff, I had to go to my manager to say … I know this person has been waiting for three days now, but I know the ward said no bed, but I don't think I'm comfortable. I can't handle this. My manager had to leave the, she listened to me, she had to leave the ward… She had to go to the other ward to see what is happening*

with this patient, this is an endocrine unit and this person is now needing intensive respiratory care … Later, that patient was moved. So I think it's about that leadership and confidence to challenge and then following up on concerns when they are raised, I think it will make a huge difference to deteriorating patient care outcomes. [C13]

One participant in the patient and carer/family member group discussed how anyone can be a leader and spoke about how cultural change occurs when everyone across the hierarchy feels comfortable to challenge.

An older consultant walked past us with [my son's] file in his hand went 'ohh, he's got ADHD. He's just being deliberately awkward' and I have to say I've never seen a nurse go over after a consultant like that and I've never seen it again … She really tore into him and said … 'you've not read that this poor child got serious allergies, and he's definitely not putting it on. But you've made an assumption' and if all nurses and right down from the HCA's and everybody and even the junior doctors could feel more confident and comfortable in the system that they could do that, then things would improve. [P/C3]

Role Modelling

Similarly, to anyone being a leader, 11 participants discussed the importance of role-modelling in setting a positive cultural tone. One participant described this in more detail:

The most powerful thing is role modelling. It's more powerful than teaching somebody. And if people are seeing that happening, they're picking up on that … culture that's being bred into the workforce. [C11]

Three clinical staff participants discussed how the professionalism students are taught can differ to what is observed in healthcare environments and identified that there is a need for role modelling professionalism to newly registered staff. One of the participants said:

Having a good role model that really makes a huge difference in how people then learn professionalism and learn all professional behaviours … Not being able to challenge [a lack of professionalism] as well must have been really hard because … the new practitioner is not able to grasp, not able to reflect, not able to kind of see how she would merge the reality between what she learned in school versus what she actually sees in the ward. [C9]

There was a difference in attitudes between senior clinical staff and the students who discussed role modelling. The four senior clinical staff participants discussed that observing a leader role model bad practice and feeling unable to speak out is "quite a common thing in practice unfortunately". While two students described that the medical student, in the vignette that the focus groups participants were shown, was a "bystander of that care" and "that change has to happen somewhere". One of the student participants discussed a need for all staff, including students, to role model best practice to avoid a cycle where people's best intentions to deliver person-centred practice do not fade:

You kind of constantly need leadership to be modelling that best practice all the time for everyone … But if they're being missed by people who hierarchically are in charge, what's gonna make the next generation keep doing what they know to be good? …It's that impetus to keep going. We can't keep relying on people's best nature, best intentions … even the best ones in the world do [not] constantly do what they know to be right if they are constantly being shut down. [C5]

Positive role-modelling was also described by two participants. One participant described an example of role modelling when using Situation, Background, Assessment, Recommendation (SBAR):

> *If we can give people scenarios and role modelling of how to use [SBAR] . . . so if a member of the team has to make that call to senior member of staff or an on-call consultant, they feel far more confident to do it. And because they hand over it in a really concise, professional way to get the information across that needs to go across the on-call consultant is really receptive. So then it's like oh that wasn't terrifying.* [C3]

Multi-disciplinary Teams

18 participants emphasised the need for multi-disciplinary teams that work collaboratively to improve patient safety. For example, one participant described this in more detail:

> *[a leader] admitting, 'I don't know what to do, but let me see if I can find someone that does'. . .it's involving other people and thinking what's your best practice? What's yours? And in terms of like leadership always involving. . .what are perceived sometimes as they're, I hate the word just, they are just healthcare assistants. They are just students. They are just nurses. They're just blah blah. Involving those people because they spend far more time. . .with patients than I do.* [C7]

Two participants described multi-disciplinary teams working collaboratively in the form of safety huddles:

> *We're doing a piece of work on safety huddles because. . . it's for everyone on shift staff have their space and time to escalate concerns. But it's part of trying to empower people and making people feel like they have a voice and can do that.* [C11]

One participant described a measure that encourages multi-disciplinary team working and enables clinical staff to admit when they did not know something and to consult another expert:

> *I was working at an A&E last week. . .and I saw immediately when I came onto the emergency floor, 'If you are seeing a patient with stroke and you need help blip this person' and I thought wow, that's so helpful. It already gives you permission to say I'm not an expert in everything.* [C1]

These views were echoed in the patient and carer/family member group. Three participants emphasised a need for multi-disciplinary team working as they have not seen this in healthcare environments:

> *I'll give you a parallel if you take your car to a garage because you don't know what the problem is. You're looked at by a multitude of experts, or at least there's a computer diagnostic that is done that covers all the possibilities. This is not the case in the NHS . . . there's not a feeling, a cohesive feeling in the NHS at all.* [P/C 7]

Documentation

10 participants discussed the importance of documentation to improve handovers and person-centred practice. One participant mentioned that documentation can be missed due to operational pressures, and another described how documentation is sometimes not fed back to the family members of patients:

> *I think escalation is very much a verbal thing, not something we document … I think there's a sort of disconnect between a patient deterioration and that situation being very stressful … The documentation part of it's not seen as a priority as much as the verbal escalation… documents in retrospect is often missed because people are operationally very busy* [C11]

Two participants in the patient and carer/family member group described the impact of inadequate documentation on patient care:

> *My mum was taken into the hospital seven years ago. The paramedics came out and said we think she's got septicaemia. They took her to hospital on blue lights on the grounds that she had septicaemia. When she got there, the doctor said, 'nah, don't think it's that' totally ignored the paramedics that have been with them for the last three hours and subsequently she died of septicaemia…Think it took me six months to actually physically get to see the consultant with my mum's file. Paramedics notes were missing. How convenient.* [P/C 3]

Culture

In this section, findings relating to culture are outlined. These include cultures of learning, person-centred practice, training, intersectional experiences, cultures of fear, and systemic issues.

Cultures of Learning

Four participants in the clinical staff/student groups discussed the importance of having a culture of learning at work in which staff are encouraging each other in a supportive and non-judgemental environment underpinned by psychological safety.

> *I question decisions on a daily basis, … it's not an argumentative, it's a learning opportunity for me as well, because it might be that I just don't understand their way of working … and sometimes it is 'I'm not sure this is the right decision, and can you explain to me why you've come to this?'* [C7]

Two participants also spoke about how a supportive and non-judgemental environment enables staff to flag potential mistakes with each other to improve patient safety:

> *If you were doing the wrong procedure or that you didn't consent the patient … the medical students and student nurse etcetera can … kind of say, oh, 'do you want this, you want that'. But I don't think people consider it like that. They think they're being ridiculed or shown up … But if that medical student had said it or felt they could say something, that would have probably saved that consultant a huge complaint* [C15]

One participant gave an example of how a culture of learning enables the team to function when a leader is absent:

> *To nurture and empower your teams, you have to be a coach and you have to be able to not only do the things that are required but teach your team to do … The best leaders are able to let go and when you are not, you know, spearheading your team, you're on annual leave or something … Your team still runs like clockwork without you being there. That is a sign of a really good leader.* [C15]

Four participants in the patient and carer/family member group discussed the need for a culture of learning in healthcare environments such as learning from incidents, openness to feedback, support, and development. One participant described a dismissive reaction from a healthcare environment after they gave feedback on their concerns being repeatedly ignored for weeks:

> *We're not complaining, but we just want to say that this happened, and can we make sure that it doesn't happen in the future and the GP listen to us recount that and looked at the notes and he said 'very difficult to see what we could have done differently … I don't see how we could use it as a learning experience', he said. And that was the managing partner of the practice* [P/C 8]

Another participant in the group, who has a professional healthcare background, linked the lack of learning from incidents to the culture of the organisation.

> *In the quality organisation, when something goes wrong, the principle has to be to kick absolute maximum learning out of what has gone on … from the most of it in healthcare in my experience… more often it's the case that it's the hospital side of the process closing*

ranks. That's the way it feels to the patient … In other words, it's damaged limitation rather than maximum learning … [P/C 9]

Feedback Systems

Issues with feedback systems and learning from incidents were identified by 11 participants in the clinical staff/student group. Two participants discussed how inadequate feedback systems can make staff and patients/carers feel that they are not listened to resulting in a lack of motivation to speak up:

> *Whereby people escalate or raise concerns and they find or feel that nothing is done about it anyway. People tend to feel like, what's the point of raising it? And that's will not be very safe at all regarding patient safety* [C13]

All 11 participants expressed a need for positive cycles of reporting, learning and implementing learnings, in other words, closing that feedback loop.

> *Looking at incidents that happen and then taking them away and say if it happens next time, we can generally approach it this way even though there might be differences, but the general way of dealing with it … so we all are equipped.* [C1]

Five participants emphasised the need for a good working relationship with a staff member, such as a clinical supervisor. Clinical supervision offers dedicated time away from practice with a supervisor in a psychologically safe space for newly registered staff to "offload, explore emotions, learn from others, positively reframe challenging situations, and gain reassurance". (Stacey et al, 2020). One participant described clinical supervision as a safe space to raise concerns and discuss feedback:

> *Also something around clinical supervision here and having a safe space to be able to discuss [concerns]. And having sort of that supervision to be able to discuss and feedback and make changes to your practice going forwards* [C10]

Two participants also discussed a need for anonymous avenues for reporting:

> *There should be some form of psychological safety or avenues to provide anonymous feedback if somebody is concerned about their identity so that we can always be finding out areas that need improvement* [C13]

For the patients and carers/family members group, six participants described feeling a loss of confidence in the healthcare system due to negative experiences of not having their feedback heard. One participant described:

> *So it's a much wider impact than 'ohh, it was just this patient so to speak, this isolated incident, this isolated death, this isolated harm'. As if that wasn't bad enough actually it impacts all of us. And you end up with a loss of confidence with probably a good five or ten people from one incident. So it undermines the system on a much bigger level than one incident or one person.* [P/C 5]

Training

Benner (2001) describes stages of a clinical competence model in which the nursing professional moves from stage one, 'novice', to stage 5, 'expert', as they progress in their career. This expertise by experience was also identified by four participants who highlighted:

> *We also probably need to take into account the experience of that nurse as well. She might be a newly qualified nurse…Have they had some management experience as well? … And then its knowing the policies and protocols and everything else that goes along with it as well.* [C4]

Contrary to Benner's work on skills acquisition, two participants discussed how newly registered nurses have the most up to date knowledge and skills:

> *I think people are coming out of university with the skills to [apply guidelines and standards] more so than our staff that have been qualified for years and years and years and are really experienced because … everything's changed in health care and nursing.* [C11]

Nine participants described that training and development should be accessible to all members of staff. This is important because of the continual changes in healthcare systems and the different specialities that work within it having different knowledge and skills. For example, three participants described how mental health clinical staff may not understand some of the procedures required for physical health assessments or treatment. In addition, other professionals, such as medical staff, may not understand the psychological and psychosocial needs of patients with learning disabilities. One participant described this as:

> *I don't necessarily think we can blame the nurses, though, because they might not have had some educational training around recognising deteriorating patients and I'm an adult nurse, so I don't have mental health training in the same way that as a mental health nurse* [C7]

Four participants discussed how EWS systems are only as good as the users. Participants suggested that simulation-type training of major incident scenarios could be helpful for all clinical staff to trial the handling of deterioration events. This type of training should be held in a safe space to allow all staff to participate without a fear of not being perceived as knowledgeable:

> *So if you don't know one thing, if you're still good, you know, and it just is this scenario from an education perspective and training perspective … I think the better training on the NEWS scores or in the vital signs … I have seen that it has improved the escalation process* [C1]

Three participants in the patient and carer/family member group, who all had professional healthcare backgrounds, discussed the importance of training for clinical staff in best practices around patient safety:

> *We'd like to make out is that most of the training for NHS staff as they are promoted … comes from within the NHS and therefore there is a tremendous potential for mistakes to be repeated. And bad practice to be passed on because they're not using expertise from outside.* [P/C8]

Experiences of IENMs and Ethnic Minorities

Six participants discussed their observations of the experiences of Internationally Educated Nurses and Midwives (IENMs) that relate to hierarchical structures and the wider culture. Participants described how IENMs may not have the confidence in speaking up in the NHS working culture:

> *Many international nurses coming from cultures where they feel somehow it's wrong or there is no room for you to challenge a senior practitioner or a doctor because they're higher in hierarchy or in experience and in knowledge, so they don't feel confident to question. However, coming over to a country like this, many of them begin to find that you have been asked to challenge or question things. They have been incidences around, OK, maybe wrong drug administration … but didn't have the confidence to approach the medical practitioner to say, 'could you review this prescription?' They just feel the doctor has prescribed it, so it's OK.* [C13]

One participant describes how skills and confidence-based training could be a solution for IENMs to feel more confident in speaking up and escalating:

> *From a cultural perspective, it may be that some form of training maybe during that transition … or education, whatever training they have may need to be implemented to accommodate having confidence to escalate concerns or challenge wrong behaviours.* [C13]

Three participants discussed how experiencing racism within hierarchal structures negatively impacts IENMs and clinical staff from ethnic minority backgrounds quality of life, confidence in the workplace, and negotiating the hierarchal structures.

> *Nurses come in, we strip them of everything. They can't do any of their practices, although they've got 10 years plus experience working in Saudi Arabia, all these different countries, which people seem to think are third world countries, they're not. They have some of the best hospitals I've ever seen in my life. And they come over… and we just take everything away from them and start them at the bare bottom. And if they want to try and progress or have some sort of things. 'Oh, you haven't been here that long'. 'You should be grateful that you're over here', blah, blah, blah. And it's such a toxic culture. [C18]*

One participant discussed how racist stereotypes affect the experiences of patients. Specifically, how stereotypes of black people 'tolerating more pain' and being 'aggressive' negatively impacts on raising worries and concerns:

> *I will speak about black patients because I have seen it … [there is] the perception that they could tolerate more pain than other people to a point where you have patients fainting … having all these things in silence and then there was a perception that the patients are aggressive and if they spoke up, the people were generally quick to say 'ohh, aggressive patient, mad patient, don't shout at me' you know, because by the time they ask for nurse, they are already in so much pain that they come across aggressive even you know in that presentation … I used to working in the hospital, I used to think, 'oh my god, god forbid, I don't want to be in the hospital bed'. The experience is awful and also the information that they are given is different* [C1]

Cultures of Fear and Blame

14 participants described a culture of fear of 'putting your head above the parapet' out of a fear of being blamed, reprimanded, or their career being affected. Four participants described experiencing and/or observing a culture of fear and blame in healthcare settings which influence raising worries and concerns. For example, one student participant discussed a fear of how speaking up may impact their assessments and grades:

> *When I talk to other students who've seen in practice, they don't agree with or had a bad time on placement, they're fear is … 'these people are signing me off. These people are doing my assessments' and maybe there's some of that kind of power that this consultant has over the future keeps that kind of hierarchical culture going because all it takes is literally to say, 'oh they're no good' and that clubs that student back* [C5]

One participant in the patient and carer/family member group wondered whether there is a fear for clinicians of speaking out due to a hierarchical power imbalance. They stated:

> *I wondered if part of the disempowerment was because of the ongoing working relationship and was the consultant, in effect a gatekeeper for accessing a resume, a reflection on that person's work? Do you in effect keep your mouth shut and … don't stand out because it will affect whether you get promotion and whether you get chosen to be part of the group that gets the next lot of experience.* [P5]

Four participants in the patient and carer/family member group also described similar feelings of fear in that speaking out could impact on the quality of care and may also negatively impact the future interactions with clinical staff. One participant observed that these feelings of fear differ between those receiving care frequently and those who receive care less frequently:

> *I found that there is a difference between me who isn't accessing services on a daily regular basis, and how empowered I feel to challenge the system and speak up and out, and how differently those who are in a care package and needing it all the time engage with it.* [P5]

Overworking and Understaffing

11 participants described a culture of overworking and understaffing, and how it negatively impacts staff's ability to deliver person-centred practice and detect patient deterioration. Participants described overworking as staff managing large numbers of patients, having limited time to spend with each patient, increasingly older populations, and illnesses becoming more complex. As one participant summarised:

> *Prioritisation of care is something that's … fizzling out … which kind of isn't anybody's fault. I think it's the nature of what we're dealing with in terms of our staff being made like very busy, short staffed, patients being sicker.* [C11]

One participant spoke about their dissatisfaction with how senior management are responding to patient deterioration and that there is a disconnect with the realities of healthcare environments:

> *We've got to look at ways of bringing what the senior management think are happening in response to deteriorating patient and escalation to actually what is happening in reality … When patients are deteriorated, [senior management] will come back and go, 'We don't quite understand what's happened' and it's like but you know we have explained that the*

wards are very busy. You know that we're running on different staffing levels. It has a massive implication [C12]

Participants described how understaffing, and overworking has a human-element and that regardless of their best intentions, clinical staff are not always able to deliver person-centred practice and instead deliver a more task-based care which can be quicker and 'easier':

I think all of these relate to seeing the patient and not just the symptoms. But that it's difficult when you worked in healthcare for a long time, it's difficult to always be human and see the human because it becomes, you know, it can be like 'oh yeah I've seen this before'. You know, you can't help it, but think I've gotta go home, actually … which we're all guilty of at times aren't we [C17]

One participant spoke about the impact of staffing levels on detecting and managing deteriorating patients:

General staffing, so … like in terms of tackling patient safety … if you as a [nurse], you're expected to work on five HCA's and five RN's and that's your, you know, your expected staffing level and you come in and you're on two and two. I think people feel sometimes that they just have to get through it and can't raise the concerns. [C7]

Seven participants specifically discussed issues with having time limitations per appointment in a General Practitioner (GP). They described how time and work pressures negatively affects clinicians ability to effectively deliver person-centred practice and recognise patient deterioration:

Time to meet … It doesn't happen in general practice and it doesn't happen in normal consultant appointments. You have your time. That is it … This is what you are. You're on that conveyor belt, aren't you? So how are you going to provide holistic, compassionate, kind care? If you have got 30 people to see from 1:00 o'clock to 4:00 o'clock. [C16]

Participants in the patient and carer/family member group did not describe a culture of overworking and understaffing, instead seven participants described experiences of receiving task-based care rather than person-centred practice. They described how this impacted on them and made them feel like a patient rather than a person:

It was like, you know, an annoying patient and … [the clinical staff] just wanted to get rid of me. You know that consultants room was like full of golf equipment and … you felt that … the priority was maybe going out for a round of golf in the afternoon that day [P/C 9]

Person-Centred Practice (PCP)

All 18 participants identified PCP as an ideal standard, and 10 participants specifically discussed the importance of PCP using examples and experiences where it has not occurred. For example:

We, as people in healthcare, go into any appointments that we're in, knowing that we're potentially gonna … have to say I'm not happy with that and I'm not happy to do this, but we're in the minority. Everyone should feel that they're able to have that conversation and everyone should be able to feel that they should be in this at the centre of their care and understand what everyone suggesting for them. [C16]

Participants described how the delivery of PCP is hindered by time pressures (as discussed in 'Overworking and Understaffing', and protocols that imply clinical staff are experts (as discussed in 'Who are the experts?'). For example, one participant described:

> *And it's probably easier… to be the nurse that goes and says this is how you're gonna do it … you're gonna take your medication at this time. We're gonna give you this …. It's simple. It follows the plan. But as you know, like no patients are like that. It's more difficult to actually fully do an assessment, you know, like holistically assess people and give them person centered care that takes time and … skill to do that.* [C8]

Two participants discussed how specialist clinics have more time to offer PCP including time to build a relationship, understand and really listen to the patient:

> *A nurse specialist [was] brought into post and so that we could look after these patients in clinic, and we get that additional time to build a relationship, understand … there's something about really listening and the patient knows when they've been heard … because I'm using their language and I'm reflecting back what they've been saying to me* [C18]

One participant described how they do what they can to offer PCP in the context of overworking and understaffing, such as remembering how a patient takes their tea:

> *I used to think, before I was a nurse, I'd be able to make a real difference. Every single one of my patients, … I'd know all about them. Everything. That's just not the case. And I even find myself saying to my newly qualified nurse on that 12-hour shift. If you could just make one small difference to one of your patients days, that's wonderful. If you make them their cup of tea the right way, that exactly [how] they like it … When I reflect on that, I think that's such a small thing. And I absolutely cling to those little sparkles of real nursing care that I thought I was going to be delivering when I come in. And if I really thought about it, it is quite upsetting, but that's all we can do right now because of where we are.* [C15]

In the patient and carer/family member group, all nine participants described PCP as an ideal standard. One participant said:

> *One of the principles at work or should be at work is, you know, two patients with a different condition and the good doctor will not deal with both those patients the same. They will assess…and they will tune their message and the way they will communicate and interact with them will be very, very different. But that's what the good consultant will do. The bad consultant, as in my example, will just do what they want to do no matter what.* [P/C 9]

Two participants observed a generational difference in the quality of care delivered from younger clinical staff than from more senior staff members. Both described a more compassionate, empowering, and person-centred approach from younger clinical staff members, one of the participants said:

> *It was the younger staff that would sit with [my son] and listen and hold his hand. And if I went out for an hour, they'd sit and they'd be nice to him and … listen and they feed information back to the nurses and the staff nurses and the consultants.* [P/C3]

Another participant in the same group disagreed with this and felt that the difference in care stems from different roles, self-belief, and experiences within their roles:

I have met many young people fresh from uni who I can't understand why they're in the job, shocking. [P/C1]

Hierarchy

Hierarchy is a system in which members of an organisation or society are ranked according to relative status or authority (Cambridge Dictionary, 2019). In this section, the following findings relating to hierarchy are outlined. These include hierarchy within culture, who is an expert, and hierarchies across professions.

Hierarchy Within Culture

16 participants described a 'traditional' hierarchal culture including attitudes from senior staff alluding to 'we've always done it this way', 'don't question me' and 'know your place'. These attitudes are interwoven into everyday interactions, the structures of an organisation, and job roles themselves. For example, one participant described how historical hierarchies are interwoven into the job titles and bands within the NHS, and they felt this does not always recognise the professional and personal experience people have.

Participants described how newly registered clinical staff and students are 'put down' as a part of 'knowing their place' in the hierarchy. For example, one participant described newly registered nurses being 'put down' for showing enthusiasm and wanting to make a mark on the profession:

> *Incredibly sad that . . . we really downplay people's sort of enthusiasm to come into the nursing profession. I mean, at the beginning of the pandemic, we were hyped up as heroes . . . if people come in and . . . they want to place their mark on nursing . . . I don't understand why we're always putting people down for that or 'oh you're trying too hard in your job'* [C15]

Participants described this process of putting down people as a cultural norm within the hierarchical culture which says, 'we have always done it this way' and being dismissive of those questioning or attempting to change those ways:

> *Certainly not easy [to speak up] because the culture or the cultural norms, the expectations always take over. But we would like to feel that we are moving that forward. And even as senior nurse, you know I have to work hard to get my voice heard* [C18]

Hierarchies Across and Within Professions

The hierarchical culture described in the previous section is apparent across and within professions. Across professions, nine participants described observing hierarchy between nurses and allied health professionals (AHPs), and consultants and junior doctors. One AHP student observed that junior doctors tend to be more 'dominating' with other theatre staff while senior consultants tend to be 'team players'. One student nurse described how they witnessed less hierarchy between nurses, and more so between nurses and consultants. This therefore lengthens the time to raise a concern as a student nurse because it goes through a senior nurse instead of directly to a consultant:

> *I've seen less of that hierarchy and culture that you can't question it within higher ranks of nursing, but I think nurses to consultant is still very much there or it's like if . . . you question it with the nurse first and then the senior nurse will question it with the consultant.* [C8]

Within professions, 10 participants discussed hierarchies within their professional groups which create cultures of fear. For example, one participant reflected on this in their profession:

> *I definitely did [experience being put down] as [a] midwife. And I have newly qualified midwives coming to me and saying the same thing being like, 'why am I doing this? … Everyone's told me that this is the worst job in the world. Why should I stay?' and there's students that we're trying to nurture and bring into the profession'* [C16]

One AHP student stated that they have not experienced hierarchies within radiography and attributed this difference to their level of patient contact:

> *We don't necessarily have a 'you shouldn't have done this', 'we're in charge' kind of vibes. We get the more, 'This isn't what we should be doing as an examination because of the presentation'.* [C5]

Hierarchies across and within professions were observed by seven participants in the patients and carers/family members group. These participants identified that the hierarchies negatively impacted their perceptions of clinical staff, but it was unclear whether these perceptions of the hierarchies amongst clinical staff directly impacted their own willingness to raise worries and concerns:

> *Consultants can be all powerful and impervious and actually clamped down in some cases very severely on anybody junior and the team who tries to … challenge [the consultant] for that.* [P/C 9]

Who Are the Experts?

13 participant discussed hierarchical attitudes of clinical staff viewing themselves as the experts over junior doctors and nurses, HCAs, AHPs, patients and carers/family members. Participants identified that these attitudes prevent multi-disciplinary teams and person-centred practice and create a culture of fear that counteracts psychologically safe environments for staff, patients and carers/family members to raise worries and concerns. One participant described this as:

> *It's just those kind of paternalistic attitudes that we have as healthcare professionals that we know best and we do have experiential learning as we kind go through our training and … our experiences as clinicians but you know you can't take away from that one [patient's] lived experience* [C3]

Seven participants suggested that clinical staff may need to present themselves as the experts because senior staff can be afraid to admit when they do not know something. A culture of learning and multi-disciplinary team working were identified as helpful in alleviating this, as one participant explained:

> *That's actually quite hard as a clinician to be able to say I need, you know, I would like some help with this or I don't know …. I think you put your head above the parapet to say 'well, I don't know what's going on' and it's not easy* [C16]

On the other hand, all participants in the clinical staff/student group discussed or agreed that all professionals are experts in their area, which was discussed in the sub-section 'Multidisciplinary Teams'.

Four participants described that older patients tend to have a 'traditional' perception of clinical staff knowing best and doing what you are told without questioning them. Participants said if this was reinforced it could to the patient not booking an appointment or raising concerns over their health:

> *It makes me feel like as a profession, we really haven't moved on, we haven't changed or learned or grown … When Matron told you to get out of bed, you got out of bed. When you were told to do this, you did it like as a patient. You were at the whim of the nurses, the doctors, everything.* [C15]

Two participants discussed how healthcare systems are changing and becoming increasingly digitised, enabling younger patients to be more involved in their care and raise concerns:

> *Younger age groups … are quite happy to challenge because, of course, they're all over Google. Dr Google, so they're gonna present their evidence, whether it's right or wrong. And so it's very different cohort that you're working with … they are not gonna be fobbed off and they are gonna be heard* [C18]

However, both participants identified that medical professionals may need to be more assertive in explaining that "everything on Google is not accurate … we don't want them spending hours on Google looking at symptoms" [C18].

16 participants in the clinical staff/students groups discussed the need to involve patients, carers and family members as 'experts' in a patient's care. This was particularly important because 'objective' 'track and trigger' measures do always identify how the patient is feeling and/or flag some of the soft signs in relation to patient deterioration The need to communicate with and actively listen to patients and carers/family members was seen as integral:

> *The patient need to be actively involved in their care because there are things we cannot even pick out through early warning scores …We all work as a team, the clinicians and the patients* [C13]

Two participants in the clinical staff group identified that while patients are experts in their lived experiences and should be involved in their care, but clinical staff have expertise and knowledge, and should be viewed as experts if the condition is new for the patient.

All participants in the patient and carer/family member group said that they felt an expert in their own lived experience. However, eight participants described not being heard by clinical staff and at times did not feel as though clinical staff viewed them as experts and felt dismissed. Examples were shared where the patient or carer/family member felt unable and/or a lack of willingness to speak up after being actively dismissed. For example, one participant explained:

> *[Our child] who has a long history of mental illness … [was] sent into hospital with severe abdominal pain and the surgeon who saw her publicly in the ward accused her of being attention seeking. 'This was psychosomatic. Look how many times she's appeared at A&E as a self-harmer'. She was 'wasting his time' … She rang us crying to be taken home and it was only because of [the father's] intervention that they discovered that she actually had a blocked bowel as well as a neurological problem that was causing her to fall, both of those things could have killed her, and she would have been sent home. This is not an isolated incident.* [P/C 8]

Participants emphasised the need to listen to patients and view them as experts. Whilst the participants acknowledge clinical staff had the best intentions, the experiences of the patient and carer/family member group highlight that the experience of being dismissed can lead to a loss of confidence in professionals and reluctance to speak up about concerns.

Discussion

The findings of the study found that participants viewed PCP as an ideal standard of care delivery in clinical settings for improving and ensuring patient safety. Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users, carers, and family members (McCormack & McCance, 2021). Through identifying the factors influencing the ability to raise worries and concerns, the findings explore a set of wider worries and concerns of the whole system that influence the delivery of PCP. These wider factors influencing the delivery of PCP largely relate to the healthcare environment and some of the prerequisites as defined in McCormack and McCance's Person-Centred Framework (Appendix 1). The findings of this study identified that these wider worries and concerns of the healthcare environment influence the quality of the care delivered to the patient through a range of activities and the expected outcomes of delivering effective person-centred care.

Prerequisites

The PCP framework identified a set of prerequisites that focus on the attributes of staff and are "key building blocks in the development of healthcare workers who can deliver effective person-centred care" including being professionally competent and demonstrating a clarity of beliefs and values (McCance & McCormack, 2021). Four clinical staff and students described that staff become professionally competent to deliver effective care as they gain more experience in their role. This echoed Benner's (2001) description of stages of a clinical competence model in which the nursing professional moves from stage one, 'novice', to stage 5, 'expert', as they progress in their career. Two participants also described that all clinical staff and students have a responsibility to demonstrate a clarity of beliefs and values by speaking out against actions that do not reflect these. Two other participants also described that all clinical staff and students must role model best practice to avoid a cycle where beliefs and values to deliver PCP do not fade.

Appropriate Skill Mix and Potential for Innovation

The healthcare environment is reflective of the complexity of the context in which healthcare is experienced (McCance & McCormack, 2021). The PCP Framework views context to be synonymous with the healthcare environment and contained within it are diverse characteristics and qualities of the environment that impact the effectiveness of person-centred practice such as appropriate skill mix and potential for innovation and risk taking (McCance & McCormack, 2021). 18 participants and three patients and carers described a need for multi-disciplinary teams in which there is a diverse range of staff with essential knowledge and skills needed to provide quality care relevant to the context. Multi-disciplinary teams were viewed as collaborative team working, providing holistic care for patients, and offering a psychologically safe way for staff to admit when they are unsure about something as they can draw on another member of the team.

The findings found that nine participants believed that training for all staff offers could offer a potential for innovation and risk taking in a psychologically safe space. This training was viewed to achieve what the PCP framework describes as exercising of professional accountability in decision-making that reflects a balance between professional judgement, local information, the best available evidence, and patient/family preferences (McCance & McCormack, 2021).

Shared Decision-Making

Systems that facilitate shared decision-making stem from organisational commitments to collaborative, participative, and inclusive ways of engaging within and between teams (McCance & McCormack, 2021). Participants described the importance of such systems through leadership role-modelling these ways of engagement, unpacking hierarchical attitudes of clinical staff viewing themselves as experts, and effectively creating multi-disciplinary teams. 13 participants described how hierarchical attitudes within clinical staff are affecting multi-disciplinary teams and person-centred practice while contributing to a culture of fear that counteracted necessary psychologically safe spaces. Participants described how multi-disciplinary teams and leadership role-modelling are effective measures in delivering shared decision-making as they are underpinned by a value of each professional and patient, carer, and family member bringing their own expertise.

Effective Staff Relationships and Supportive Organisation Systems

Effective staff relationships and supportive organisational systems were characteristics of the person-centred practice framework's healthcare environment that were discussed by 11 participants in the form of feedback systems. Interpersonal connections between clinical staff and students, such as clinical supervision, offer psychologically safe spaces for staff members and students to raise worries and concerns. Organisational systems that offer anonymous feedback methods and closing of feedback loops promote the safety of patients and staff. These systems are underpinned by an emphasis on valuing patient safety, psychological safety for staff, and accountability. The organisational feedback systems are vital to extend to patients, carers, and family members as six participants described a loss of confidence in systems due to experiences of not having their feedback heard.

Power Sharing

Power sharing entails non-hierarchical relationships that do not exploit people, but rather are concerned with achieving the best mutually agreed outcomes (McCance & McCormack, 2021). The findings found that hierarchy within cultures and between clinical staff create a culture of fear and blame that negatively influences the ability for power-sharing, shared decision-making systems, effective staff relationships, and potential for innovation and risk-taking. Leadership that role models and demonstrates hierarchical behaviour breeds that into the culture of the healthcare environment. However, participants identified that power sharing occurs when leadership encourages multi-disciplinary team working and cultures of learning, and values the expertise of all staff, patients, carers and family members.

Physical Environment

The physical environment is one of the defining characteristics of the healthcare environment within the person-centred framework (McCance & McCormack, 2021). Health and care institutions are often characterised as understaffed and overworked, which negatively impact on staff wellbeing and patient safety (Maben et al, 2012; Aiken et al, 2014). Overworking and understaffing impacts staff's ability to continuously role model a leadership that delivers person-centred practice, multi-disciplinary teams, and cultures of learning. Participants attributed overworking due to large numbers of patients, limited time to spend with each patient, increasingly older populations, and illnesses becoming more complex. Despite best intentions, clinical staff are not always able to deliver person-centred practice and detect patient deterioration which requires time and attention. Instead, staff may deliver more task-based care which can be quicker and 'easier' under work and time pressures. Patients, carers, and family

members participants described how receiving task-based care creates a feeling of being treated as just another patient rather than a person, and few attributed this task-based care to systemic issues of overworking and understaffing.

Overall, the findings identified that the characteristics of the healthcare environment, especially concerning leadership, influence the quality of the care delivered to the patient. Healthcare environments that encourage multi-disciplinary team working, valuing the expertise of all stakeholders, person-centred practice delivery, and cultures of learning is key to setting a positive working culture in which all clinical staff and students, patients, carers, and family members feel confident in raising worries and concerns. In healthcare environments where leadership is more hierarchical, training and development for staff and students, and avenues for feedback can provide psychologically safe spaces for clinical staff and students to deliver person-centred care. Nevertheless, healthcare environments are often characterised by a culture of overworking and understaffing which limits clinical staff and students best intentions of providing person-centred practice as limited time and increased work pressure incentivise delivery of more task-based approaches.

Recommendations

The findings suggest that the healthcare environment has a major influence in utilising prerequisites, delivering person-centred processes, and seeing person-centred outcomes as characterised in the PCP Framework (Appendix 1). Considering the findings, the recommendations of this study are the following:

1. Provide adequate avenues for feedback as a supportive organisational system and strengthening of effective staff relationships: implementing and encouraging the usage of anonymous feedback, clinical supervision for all practitioners including students, and protected supervisory support for clinical staff to ensure a psychologically safe space for staff to raise worries and concerns.
2. Ensure closure of feedback loops as a supportive organisational system: communicating the learnings and actions taken after feedback to the wider team as it encourages staff to raise their worry and concerns.
3. Promote and facilitate patients to become more involved in their care for power sharing and shared decision making: for example, digitally enabled practices, such as the NHS app and personal health record service provisions can empower patients to become more involved in their care and decision-making. Healthcare is moving into a new era of digitally assisted decision making, contributing to achieving effective person-centred practices.
4. Provide and promote opportunities for patients, carers and family members feedback as a supportive organisational system and power sharing: opportunities for feedback from patients, carers and family members assist in developing a working culture that prioritises psychological safety to raise concerns and patient safety improvement. This is one of the approaches to involving patients in their own healthcare and safety in the NHS Patient Safety Strategy (2021).
5. Provide and promote patient safety partner (PSP) involvement to improve appropriate skill mix and power sharing: PSP involvement in healthcare organisations can include membership of safety and quality committees, working with organisation boards to improve safety, or participation in investigation oversight groups (NHS, 2021). PSP involvement offers valuable insight of patients in healthcare environments and can inform the development of safety solutions, including raising worries and concerns and having them be appropriately acted upon (NHS, 2021).
6. Provide training sessions for all clinical staff, relevant non-clinical staff who are likely to spend more time with patients, such as cleaners and porters, and students on detecting and escalating recurrent and major patient deterioration incidents to provide potential for innovation and risk taking, and improve healthcare environments appropriate skill mix: all clinical and non-clinical staff and students receiving effective training on detecting and escalating patient deterioration events empowers them to practice and learn skills, especially intuition, in a psychologically safe environment without fear of blame or reprimanding.
7. Prioritise staff wellbeing in healthcare environments: healthcare environments shoulder deliver primary interventions to support the wider care environment pressures that impact clinical staff wellbeing and retention. Burnout is a result of several work-related factors including chronic excessive workload, lack of voice and influence, lack of recognition, inadequate teamworking, inadequate leadership, and cultures of fear and blame (West & Coia, 2019; West et al, 2020). Primary interventions tackling the causes, instead of the symptoms of burnout, are needed such as nurturing a psychological safe culture, proactively ensuring diversity and universal inclusion, creating shared decision-making opportunities for all staff, developing and supporting multidisciplinary teamworking, ensuring compassionate leadership, and tackling chronic excessive workload (West et al, 2020).

8. Empower newly registered staff and students to practice power sharing and shared decision making: to provide leadership skills development and encouragement in psychologically safe manners for newly registered staff and students assists in enabling power-sharing and shared decision-making required in healthcare environments to deliver PCP.
9. Commission research to explore cultural background influences: there are limited studies that explore the experiences of clinical staff, students, patients, their families and/or carers of global majority backgrounds and/or internationally educated backgrounds on the factors influencing their ability to raise worries and concerns. While this study explored this briefly, the interplay and relationship between leadership, culture and hierarchy and cultural background influences is a key area. Further research should be conducted to provide equitable and holistic interventions and in the goal of achieving psychological safe environments needed to deliver PCP.
10. Commission research to explore generational differences: participants had differences in perspectives around how different age groups of clinical staff provide person-centred care and the relationship between age and the care provided.
11. Commission research to explore consultants' perspectives: the majority of clinical staff and students who participated in this study come from a nursing background. Further research would benefit from exploring consultants' experiences raising worries and concerns to provide a more reflective account of all clinical staff perspectives on the influence of culture, leadership and hierarchy in raising worries and concerns on patient deterioration.

The recommendations for changes within the healthcare environment to encourage and facilitate culture, leadership and hierarchy to prioritise and encourage the delivery of PCP and are shown in Table 1.

Table 1: Healthcare Environment Change Recommendations

PCP Framework factor:	Related Recommendation(s):
Effective staff relationships	(1) Clinical supervision for all practitioners including students and protected supervisory support for clinical staff.
Supportive organisational systems	(1) Implementing and encouraging the usage of anonymous feedback. (2) To ensure closure of feedback loops. (4) Provide and promote opportunities for patients, carers and family members feedback.
Physical environment	(7) Prioritise staff wellbeing in healthcare environments.
Power sharing	(3) Promote and facilitate patient involvement in their care. (4) Provide and promote opportunities for patients, carers and family members feedback. (5) Provide and promote patient safety partner (PSP) involvement. (8) Empower newly registered staff and students.
Potential for innovation and risk taking	(6) Provide training sessions for all clinical staff on detecting and escalating recurrent and major patient deterioration incidents.
Appropriate skill mix	(5) Provide and promote patient safety partner (PSP) involvement. (6) Provide training sessions for all clinical staff on detecting and escalating recurrent and major patient deterioration incidents.
Shared decision-making	(3) Promote and facilitate patient involvement in their care. (8) Empower newly registered staff and students.

Limitations

The focus groups participants comprised of 18 clinical staff and students, and nine patients and carers/family members. The clinical staff and student group consisted of one midwife, two AHPs and 15 nurses so the largest group of participants were from a nursing background, limiting the findings from a particular perspective and healthcare background. The findings therefore may provide reasonable representation of a specific professional group rather than other stakeholder perspectives in relation to patient deterioration. Thus, less is known about other clinical staff's perspectives in relation to patient deterioration.

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Appendix 1

The Person-Centred Practice Framework (McMance & McCormack, 2021).