Transformation Partners
in Health and Care

Medical voice: listening with purpose to our consultant and SAS doctor workforce

Independent report

July 2026

Contents

Acknowledgements

The research team would like to extend our sincere thanks to all the consultants and SAS doctors who participated in this listening activity.

Your openness, honesty, and willingness to share your experiences have been invaluable in reinforcing feedback already available through many other listening exercises and investigations. We would especially like to thank those who spoke to us, despite initial hesitations – thank you for trusting us.

What is needed now is continued involvement, alongside strategic action. Your contributions provide an essential foundation for meaningful and sustainable improvement.

We recognise that some of the experiences shared may feel uncomfortable to reflect on or discuss. However, open and honest dialogue is critical to enabling genuine listening and learning. This work has been approached with the intention of understanding lived experience, rather than re-examining individual incidents or investigations.

While this report does not seek to explore or resolve specific cases, the insights shared collectively offer an important reflection of how it feels to raise concerns within this organisation.

Section 1

Executive summary and emerging priority actions

Executive summary

1. Introduction

The independent *Medical voice: listening with purpose to our consultant workforce* exercise ran across much of April and May 2026 and was commissioned by Cambridge University Hospitals NHS Foundation Trust (CUH).

The work was delivered by TPHC (Transformation Partners in Health and Care) an independent NHS-based consultancy with expertise in supporting organisational transformation.

The purpose of the listening exercise was to gain a deeper understanding of consultant and SAS doctor experiences in relation to speaking up, psychological safety, and how concerns are raised and responded to within the organisation.

TPHC provided a neutral and confidential space in which consultants and SAS doctors could share their lived experiences openly and synthesised these insights into themes to support organisational learning and improvement.

This activity forms part of CUH's broader commitment to strengthening openness, listening, and responsiveness across the organisation following:

1. informal internal reviews and listening exercises
2. external reviews (such as Verita)
3. increased focus on understanding and shifting National Staff Survey results

This Executive Summary outlines the key findings included within the report, together with a set of emerging priority actions.

2. Reach and representativeness

Although no qualitative exercise can claim statistical significance, findings demonstrate compelling evidence of thematic saturation and organisational relevance from within the sample of participants.

The exercise engaged approximately 19% (233 participants) of the consultant and SAS doctor workforce (including honorary, academic and part-time staff). Engagement was across 45 interviews, 7 meetings and 128 survey responses, achieving broad representation across specialties, divisions and demographic groups.

Findings were remarkably consistent across engagement methods.

There are some important factors to consider when reading the Executive Summary and main findings:

- **Participation was higher in specialties involved in recent or ongoing reviews**, with experiences recorded here being on the most challenging end of the spectrum. Naturally, this has altered the balance of the findings.
- **Some smaller specialities/ less frequently heard voices came forward because we specifically asked for them, rather than because they had specific issues to raise** – this indicates there is a cohort of consultant and SAS doctors who feel well supported and have positive experiences of working within the organisation.
- **Many participants have had poor experiences of previous organisational leadership within CUH.** Where possible, we have distinguished between experiences which are historic vs current, to accurately reflect which are live issues with the current leadership.

Further engagement work should be undertaken with the wider consultant and SAS doctor cohort to determine if these findings resonate more widely and therefore can be considered truly representative.

3. Development of the Key Lines of Enquiry (KLOEs)

To guide engagement activities, a series of KLOEs were developed, based on specific issues CUH wished to explore further. These were based on existing intelligence from the National Staff Survey, Verita findings and other listening processes within the organisation.

The KLOEs span eight distinct themes related to medical voice. Section five aligns qualitative and quantitative findings to these to outline consultant and SAS doctor experience.

1. Psychological safety and voice
2. Representation, credibility and fairness of voice
3. Risk, early warning and organisational intelligence
4. Learning, prioritisation and visible ownership
5. Follow-through, trust and confidence
6. Inclusion, belonging and equity of experience
7. Blind spots, strategic gaps and unmet priorities
8. Surfacing best practice

Executive summary

4. Findings across Key Lines of Enquiry

Participants demonstrated a strong commitment to patient care, service improvement and organisational success. Consultants and SAS doctors described a workforce that wants to be more engaged, is aware of risks and are generally motivated to contribute to organisational improvement.

The primary challenge is not the ability to raise concerns. Participants generally understood how to identify risks, escalate issues and contribute ideas. The findings suggest that CUH does not face an absence of medical voice. Rather, the challenge is ensuring that medical voice is consistently heard, valued and acted upon across all parts of the organisation.

4.1 Trust, transparency and visible action underpin confidence

Participants consistently described trust as being built through visible action, transparency and follow-through. Confidence was highest where concerns were acknowledged, discussed openly and accompanied by clear communication regarding decisions and next steps.

Many participants distinguished between being able to raise concerns and believing that raising concerns would make a difference. Where concerns were perceived to result in visible action, confidence in organisational processes increased. Where concerns appeared unresolved, delayed or difficult to track, confidence reduced.

4.2 Experiences of voice, influence and psychological safety are not consistent

Experiences varied significantly between specialties, divisions and teams. While many participants described psychologically safe environments, supportive leaders and inclusive team cultures, others reported barriers to speaking up, concerns about influence and inconsistent experiences of organisational responsiveness.

Participants described influence as being shaped by factors including professional networks, seniority, specialty status and proximity to leadership. Some participants also described differential experiences associated with gender, ethnicity, communication style, disability, caring responsibilities and career stage.

4.3 Local cultures are often stronger than organisational systems

Positive practice was noted at a local level within the organisation, particularly when leaders were visible, approachable and responsive, multidisciplinary challenge was encouraged and concerns were discussed openly.

Many participants reported greater confidence in resolving concerns locally than through organisational escalation routes. This created a perception that medical voice is often strongest where local leadership and team cultures are effective.

4.4 Confidence reduces as concerns move further from the frontline

Participants frequently described uncertainty regarding what happens after concerns are escalated beyond local teams. Concerns included limited visibility of decision-making, uncertainty regarding ownership and inconsistent feedback on outcomes.

Many participants questioned whether concerns, risks and frontline experiences are fully understood as they move through organisational structures. This contributed to a perceived disconnect between frontline experience and organisational decision-making.

4.5 Organisational priorities and structures shape confidence in speaking up

Broader organisational factors influence experiences of speaking up such as operational pressures, workforce challenges, financial constraints and organisational complexities.

Participants repeatedly described perceived tension between operational priorities and clinical judgement. Participants also described uncertainty regarding the respective roles and influence of clinical leadership, operational management and medical staffing functions.

4.6 Existing strengths provide a strong foundation for improvement

Participants consistently identified examples of excellent leadership, strong team cultures and effective local practice. Positive examples included psychologically safe teams, collaborative multidisciplinary working, visible and responsive leaders and effective local problem-solving.

Importantly, participants remained strongly committed to improving the organisation. Many expressed hope that increased organisational listening, external scrutiny and evolving leadership approaches provide an opportunity to address longstanding concerns.

Executive summary

5. Strategic themes for wider organisational consideration

Participants frequently raised issues extending beyond the direct scope of speaking up, engagement and organisational culture. These themes emerged consistently across interviews, meetings and survey responses and were often described as influencing consultants' confidence in organisational decision-making and responsiveness.

While detailed solutions sit outside the scope of our emerging priority actions, they warrant wider organisational consideration because of their influence on consultant and SAS doctor experience and confidence in speaking up. And, indeed, work may already be underway to address some of these issues. Participants frequently described them as shaping confidence in leadership, organisational responsiveness and the ability of consultants and SAS doctors to influence change.

5.1 Operational management and clinical leadership

Participants frequently described tension between operational priorities and clinical judgement. A recurring perception was that clinicians are increasingly required to support operational targets, while operational systems are not always configured to support the delivery of safe and sustainable patient care. Participants also questioned whether clinical expertise is consistently incorporated into decisions affecting services, capacity and workforce planning.

5.2 Clinical leadership capacity and effectiveness

Many participants described clinical leadership roles as structurally challenging, with limited protected time, administrative support, training or authority. Clinical leaders were often viewed as responsible for influencing decisions without possessing the resources or organisational leverage required to deliver change. Participants questioned whether current arrangements enable clinical leaders to fulfil both operational and professional leadership responsibilities effectively.

5.3 Governance complexity and organisational learning

Participants frequently described governance structures as complex, fragmented and difficult to navigate. While concerns were often escalated appropriately, participants were less clear about how concerns progressed through governance systems, how priorities were determined and how organisational learning was translated into action. Questions were also raised about accountability, ownership and the implementation of recommendations arising from reviews and investigations.

5.4 Workforce sustainability and organisational culture

Participants highlighted wider concerns relating to workload, workforce pressures, burnout, succession planning, belonging and organisational cohesion. Several described a perceived erosion of relationships and organisational connectedness following COVID, alongside concerns regarding inconsistent experiences of inclusion and influence across different staff groups.

5.5 Operational and digital risks

Participants identified a range of operational and digital challenges that they believed affect service delivery, patient care and workforce experience. Examples included workforce shortages, capacity constraints, fragmented systems and technology that does not consistently support clinical workflows. Participants often described these risks as well recognised locally but not always addressed at organisational level.

6. Alignment with the Verita report

Comparing the findings in this report with those in Verita highlights **significant overlaps**, but also some important differences in scope and emphasis.

The two reports are remarkably aligned on several cultural and organisational issues, despite approaching them from different starting points.

Key areas of consensus

1. Concerns being raised, but not acted on
2. Reframing substantive concerns as interpersonal conflict
3. Weaknesses in organisational learning
4. Governance complexity and accountability gaps
5. Cultural barriers to change
6. Leadership visibility and frontline understanding

Where this report goes further

1. Disconnects between operational management and clinical leadership
2. Clinical leadership roles feeling structurally constrained
3. Equity of influence and insider-outsider dynamics
4. Organisational belonging and workforce culture
5. Operational and digital safety risks
6. Organisational strength in identifying risks, but not in resolving them

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Section 1.1

Emerging priority actions

The following actions are presented as cohesive and interdependent, with no hierarchy of importance, as each is considered essential to strengthening consultant voice and the organisation's listening and response culture. Each links directly to one of the six findings in section 4 of the Executive Summary.

A wide range of detailed and specific suggestions were shared through the engagement process which fall, technically, outside of the scope of this work – focusing on areas of governance, organisational design and corporate process. These suggestions are important enablers for increasing medical voice and have been synthesised into a set of high-level, action focused themes to support clarity, consistency, and organisation wide implementation. They can be found in Appendix 2.

The actions specifically focus on strengthening the conditions that enable consultant voice to be heard, acted upon, and translated into sustained organisational improvement.

Section 5 provides the full thematic analysis, including additional insights and suggestions raised through the engagement.

Although strong themes in our report, we have not included actions around the following areas, as these have already been raised during the Verita report. However, we wanted to signal their importance by calling them out here:

- *Speaking up policies*
- *Freedom to speak up processes*
- *Investigation frameworks*
- *Behavioural standards*
- *Generic leadership visibility*
- *Psychological safety training*

Emerging priority actions (1/3)

1: Demonstrate that medical voice leads to visible action

Develop a consistent organisational approach to closing the feedback loop following concerns, suggestions and escalation of risks raised by consultants and SAS doctors.

This should include:
- acknowledgement of concerns raised;
- clear ownership of actions;
- regular communication regarding progress;
- and transparency where action is not possible and why.

Success measures
- Improved confidence that concerns are acted upon.
- Increased positive responses to staff survey questions relating to speaking up and organisational responsiveness.
- Reduction in reports of concerns disappearing or being repeatedly raised.
- Evidence of regular communication regarding themes raised and actions taken.

2: Strengthen inclusive participation and psychological safety

Strengthen opportunities for consultants and SAS doctors from all backgrounds, specialties and career stages to contribute to organisational discussions, challenge and decision-making.

This should include:
- multiple routes for participation;
- anonymous and informal opportunities to raise concerns;
- and targeted engagement with less-heard groups.

Success measures
- Increased participation across specialties and staff groups.
- Improved perceptions of fairness, inclusion and influence.
- Improved measures of psychological safety.
- Reduced variation in experience between staff groups.

Emerging priority actions (2/3)

3: Increase transparency, ownership and visibility of escalation processes

Increase transparency regarding how consultant and SAS doctor concerns are reviewed, escalated and resolved, ensuring concerns have visible ownership and clear progression through organisational processes.

This should include:
- named clinical and operational ownership of significant concerns;
- clear escalation pathways;
- and routine feedback regarding outcomes and decisions.

Success measures
- Increased understanding of escalation routes and governance processes.
- Improved confidence in organisational escalation mechanisms.
- Reduction in reports of concerns being lost, diluted or unresolved.
- Improved perceptions of accountability.

4: Strengthen clinical engagement in organisational decision-making

Develop more consistent and visible mechanisms for consultants and SAS doctors to influence decisions that affect clinical services, workforce planning and patient care.

This should include:
- regular opportunities for direct dialogue between clinical and operational leaders;
- meaningful engagement before decisions are finalised;
- and transparent communication regarding how clinical input has informed decisions.

Success measures
- Improved perceptions of involvement in decision-making.
- Increased confidence that clinical expertise influences organisational decisions.
- Positive feedback regarding engagement and consultation processes.
- Evidence of clinical input shaping service changes and improvement initiatives.

Emerging priority actions (3/3)

5: Strengthen the Clinical and Specialty Lead roles to enable effective service leadership and informed decision making

Review how key clinical leadership roles are supported to ensure they are able to lead services effectively, make decisions and take action, while drawing on and reflecting the perspectives of consultants and SAS doctors.
This should include:

- clear definition of role purpose, responsibility and decision making authority;
- protected time to gather and escalate concerns;
- leadership development focused on influencing decision making and managing complex workforce and service challenges;
- and regular communication back to teams regarding issues raised and actions taken.

Success measures

- Increased confidence in clinical leadership representation.
- Increased clarity of roles, responsibilities, and decision-making authority.
- Increased visibility of concerns raised through clinical leadership structures.
- Positive feedback regarding communication between clinical leaders and consultant teams.

6: Use consultant voice as a strategic source of organisational learning

Develop a systematic approach to identifying, analysing and responding to themes emerging from consultant and SAS doctor feedback, concerns and escalation routes.

This should focus on using medical voice as a source of organisational intelligence to identify recurring issues, emerging risks and opportunities for improvement.

Success measures

- Regular thematic reporting of consultant and SAS doctor concerns.
- Evidence of recurring themes being identified and addressed.
- Reduction in repetition of the same concerns over time.
- Increased confidence that organisational learning is taking place.

Maintain momentum and demonstrate progress

Alongside the emerging priority actions, medical voice will be strengthened through continued implementation of recommendations arising from previous reviews, including Verita, while providing transparent updates on progress, impact and areas where further improvement is still required.

Section 2

Context and purpose of the listening activity

Context and purpose of the listening activity

Understanding workforce culture

Cambridge University Hospitals NHS Trust (CUH) has placed a strong emphasis on understanding and strengthening workforce culture, particularly in relation to speaking up and psychological safety.

In April 2026, the organisation commissioned Transformation Partners in Health and Care (TPHC) to undertake the medical voice listening exercise, aimed at hearing from all consultants and SAS doctors across the five divisions.

Understanding lived experience

CUH sought to understand not only whether staff feel able to speak up, but also how that experience is shaped by local team dynamics, leadership behaviours, organisational processes and to identify where experiences may vary across divisions, specialties, and roles.

To do so, this listening exercise offered significant anonymity for participants, ensuring we could capture the most honest feedback.

Building on Verita findings

This listening activity was commissioned, in part, to build on and deepen the organisation's understanding following the findings of the Verita review, which highlighted the importance of organisational openness, the ability of staff to raise concerns, and the consistency with which concerns are heard and addressed.

The Verita work identified areas where CUH could further strengthen aspects of culture and responsiveness, and the medical voice listening exercise provides an additional, staff centred, perspective on these issues.

Complementing staff survey results

This listening activity complements CUH's existing staff survey data by providing depth and context. While the staff survey provides important quantitative insight into staff perceptions, they do not always capture the nuance of individual experience or the reasons behind those perceptions. Through direct engagement with consultants and SAS doctors and medical academics, this work enables a deeper exploration of the factors that influence psychological safety and the experience of raising concerns.

Section 3

Methodology and design principles

Methodology

This listening activity employed a mixed-methods, participatory approach, informed by detailed Key Lines of Enquiry, to provide a comprehensive understanding of consultant and SAS doctors experiences of speaking up and being heard within the organisation.

Design principles

- **Our target audience** focused on **consultants and SAS doctors** across all divisions within CUH. Participation was voluntary, and efforts were made throughout the engagement period to encourage a broad and representative range of voices through active monitoring of representation and chaser emails, sent out from CMO inbox.
- **Our engagement approach** was informed by an initial survey (with 119 responses), conducted to understand how clinicians preferred to be engaged in the listening activity. The results indicated a clear preference for confidential one-to-one interviews, participation through existing team and divisional meetings, and access to anonymous written feedback channels. We tailored our approach to meet these requests.
- **A mixed-method approach** was implemented, combining confidential 1:1 interviews (virtual and in person), attendance at team and divisional meetings, encouraging the submission of additional information via email and an online survey to provide an anonymous feedback channel.
- **Being responsive to feedback,** we routinely altered our engagement approach. This included adding evening sessions, increasing in-person opportunities, and attending existing meetings to improve accessibility.
- **Regular communication** was maintained through update emails to encourage participation and demonstrate responsiveness.

- **These adjustments were made to reflect the principles of the exercise itself: that listening should be active, responsive, and inclusive.**

Ethical considerations

The listening activity was designed with a focus on transparency, inclusivity, and psychological safety. Following each 1:1 interview, participants completed a short Mentimeter survey to capture their experience of feeling listened to, heard, and whether they felt psychologically safe. Results were regularly reviewed to identify any improvements required to the process, as set out in the design principles. However, feedback was unanimously positive.

Confidential and secure: All data collected through this process was handled with strict attention to confidentiality and ethical principles. Contributions were analysed by a small team, to reduce the number of people reviewing outputs. Anonymous quotes found within this report have been included and signed off by interview participants themselves or by written consent via the survey. No raw data has been provided to CUH.

Trust and credibility: Clear communication was included as part of all engagement methods, focussed on the purpose of the listening exercise, how insights would be used, and feedback loops, so that participants understood how their data would be used.

Analytical notes and terminology

This listening activity provides a robust and comprehensive summary of views across the consultant and SAS doctors. We include here a brief overview of terminology and analytical notes, to support understanding of this report and to be clear about its limitations.

Analytical notes

Thematic analysis: This listening exercise resulted in the in collection of a significant volume of qualitative data. The analysis therefore focused on identifying and quantifying recurring themes across the dataset, so that the scale of issues presented is clear. Therefore, very individualised situations may not have been included.

Themes were identified through repeated patterns across interviews, emotionally salient narratives and divergence between groups or settings.

The analysis took a human first approach, with all outputs reviewed and analysed by our team, with a back-up AI review to ensure no details were missed.

Limitations: As with any voluntary listening activity, there are limitations. Participation varied across divisions and specialties, and some demographic data was incomplete due to non-mandatory survey questions/ data collection being inappropriate in group settings. The findings therefore represent a synthesis of participant views, rather than a definitive account of all staff experience.

While qualitative findings cannot be considered statistically representative, the recurrence of themes across approximately 19% of the consultant and SAS doctor workforce, including representation across divisions and demographic characteristics, provides strong evidence of thematic saturation and organisational relevance.

Terminology

Throughout the report we repeat several terms. The definition of these, we have included below:

- "Participants" denotes those who actively engaged in the listening exercise.
- "Consultants and SAS doctors" we use this term to encompass honorary, academic, substantive, and part-time consultants also.
- "Senior leadership" encompasses CMO, CPO and other Board level representatives.
- "Clinical leadership" encompasses Clinical Leads, Specialty Leads, Clinical Directors, and Divisional Directors.
- Middle management encompasses Clinical Leads, Clinical Directors, Divisional Directors, nursing and operations management.

Quantification:

To improve consistency and support interpretation of prevalence across the dataset, the following language framework has been applied throughout the report:

- Unanimous / all: 100% of participants
- Most / vast Majority: >75% of participants
- Majority: >50% but <75% of participants
- Many: approximately 50% of participants
- Some: >20% but <50% of participants
- Few: approximately 10–20% of participants

Where themes are particularly concentrated within certain professional groups, departments or specialties, this has been explicitly highlighted.

Section 4

Who we heard from: The consultant and SAS doctor workforce profile

The findings presented in this section are a high - level overview and draw on demographic and other data collected across all engagement methods, including survey responses, confidential one-to-one interviews and discussions held within team and divisional meetings. A full breakdown of demographics, reach and representation is available in Appendix 1.

Anonymised workforce data, provided by the Medical Staffing department, has been included to assess how representative the participant group is of the wider consultant and SAS doctor workforce profile.

Overview of engagement

The listening exercise engaged 233 consultants and SAS doctors, gathering feedback from a broad cross-section of the workforce across divisions, specialties, tenure and experience levels. While the sample captures a diverse range of perspectives, it shows stronger proportional engagement from female and white consultants, with comparatively lower participation from male and global majority (GBE) groups. Overall, the cohort is diverse but should be considered demographically indicative rather than fully representative. Identified gaps may provide helpful guide to priority groups for future engagement and organisational listening efforts.

227 consultants out of a total 1178 *(substantive and honorary)*

6 SAS doctors out of a total 43

19% of total consultant and SAS doctor workforce*

115 **23%** of the female consultant workforce

96 **14%** of the male consultant workforce

122 white consultants, **19%** of white workforce

36 global ethnic majority consultants, **12%** of GBE workforce

44 consultants in clinical leadership roles

82 consultants in non-leadership roles

Participation was achieved through a mixed-method approach, including survey responses, one-to-one interviews, and group discussions within existing meetings. This range of engagement methods enabled access to clinicians with different working patterns, preferences and time constraints.

128 survey responses

48 1-1 interviews

58 consultants engaged through **7** team meetings

* *233 participants vs 1221 consultants and SAS doctors (as per data provided by Medical Staffing team, April 2026)*

Divisional and speciality representation

The listening activity engagement spanned specialties, divisions, and roles, providing broad organisational insight.

Engagement was achieved across all five divisions, ensuring representation from across the organisation's clinical structure. Participation was strongest in Divisions A and E, where engagement exceeded expected proportions, relative to workforce size. Division C showed moderate engagement, while Divisions B and D were less well represented.

Input was captured from a wide range of specialties, reflecting the complexity and breadth of CUH services.

Participation was strongest in high-acuity frontline areas such as anaesthesia and critical care, oncology, paediatrics, and emergency medicine. But, targeted monitoring and engagement ensured input from smaller, high complexity specialties also.

Out of the **233** consultants and SAS doctors, **44** respondents were in formal leadership roles and **82** in non-formal-leadership roles. The engagement also included those on varied contract types, including **7** academic consultants and **5** honorary contract holders.

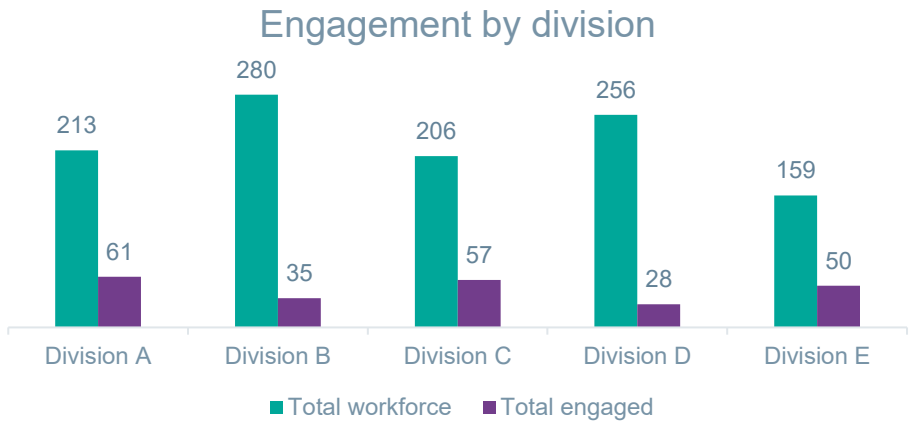

Figure 1: Engagement by division

Top specialities (most frequently engaged)

1. **Anaesthetics/Critical care** (largest group)
2. **Oncology**
3. **Paediatrics**
4. **Emergency Medicine**
5. **Surgical specialities** (general, breast, plastics, neuro, vascular, urology, ortho)

Section 5

What we heard: core themes from the listening activity

This section sets out the core themes identified through the listening exercise, drawing together insights from across all engagement methods to reflect the lived experiences of consultants and SAS doctors.

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Section 5.1 Psychological safety and voice

Psychological safety appeared as one of the strongest and most recurrent themes.

Approximately three-quarters of participants described either:
- *fear associated with speaking up,*
- *concern about repercussions,*
- *emotional fatigue,*
- *or low confidence that concerns would be addressed.*

Many participants described teams where concerns can be raised openly and challenge is viewed as part of maintaining high-quality patient care.

Examples of positive practice included:
- *supportive local leadership that encourages discussion and challenge*
- *multidisciplinary teams where different perspectives are actively sought*
- *specialty meetings that create space for open debate*
- *leaders who acknowledge concerns, even where immediate solutions are not available*
- *cultures where patient safety concerns can be raised without hesitation.*

Participants consistently linked psychological safety to visible, approachable leaders and strong team relationships.

5.1.1 Fear of repercussions and retaliation

Most participants described either direct or indirect concern about repercussions associated with speaking up – both in relation to past and present experiences. In several instances this fear manifested physically, with a handful of participants describing dread, disassociation and avoidance in relation to dealing with reporting issues.

Qualitative data gives the impression of stronger negative feelings towards speaking up, compared to survey findings – likely because participants were able to expand on issues. Figure 2 highlights that almost equal percentages of survey respondents disagreed/strongly disagreed (40%) as agreed/strongly agreed (43%) with the statement "I feel safe raising concerns when something does not seem right". This emphasises differences across qualitative and quantitative data.

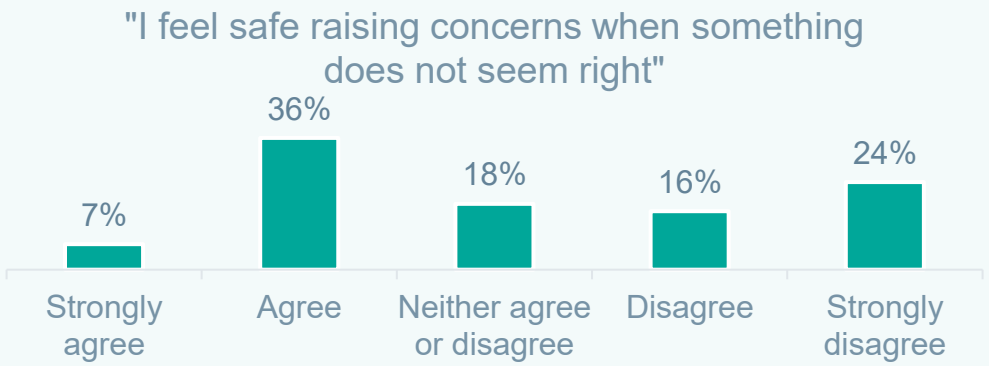

Figure 2: Safety levels when raising concerns

Actual or perceived consequences of speaking up or raising concerns included:

- being (incorrectly) labelled as difficult, confrontational, or unmanageable by senior leadership and middle management,
- subtle exclusion from meetings or decision-making,
- reputational damage,
- quiet sidelining,
- grievances or investigations – wherein by speaking up and raising concerns, they themselves would become the subject of a grievance or investigation,
- loss of opportunities - such as promotions or the ability to enact service change,
- social isolation – colleagues not wanting to become attached to someone known for speaking up or raising concerns,
- and reduced influence within teams.

These actual or perceived consequences were most observed as having happened to other colleagues, with a small minority describing these as direct experiences.

> I have seen colleague's whose professional lives have been destroyed by CUH for speaking up because it was easier to silence that person than address the actual issue - Survey respondent

Several participants described evidence, proposals or concerns appearing to disappear after escalation, with the perception that issues were being suppressed or dismissed. Others described messages becoming diluted or reframed as they moved upward through governance structures, to support the perception that there are no issues within departments or divisions.

5.1.1 Fear of repercussions and retaliation (continued)

A recurring theme was that concerns relating to patient care were perceived as safer to raise than concerns relating to colleagues, leadership, behaviours or organisational decision-making. Patient safety remains a strong priority for the consultant and SAS doctor workforce. Many participants felt that, once concerns affected individuals, professional relationships or organisational reputation, the risk associated with speaking up increased significantly.

A few participants described direct experiences where investigations became focused on the individual raising concerns rather than the underlying issue itself. Others perceived organisational responses as being more focused on managing risk, reducing escalation or protecting organisational reputation than addressing root causes. This was often due to indirect experiences of seeing colleagues involved in formal processes, as well as those who had formed views based on repeated organisational stories and observed outcomes. Collectively, these experiences and perceptions contributed to a view, among some participants, that issues can sometimes be contained or managed rather than fully resolved.

Several participants described observing colleagues experience negative consequences after speaking up, contributing to caution, disengagement and self-censorship among wider teams.

Departments where these themes appeared particularly prominently included:

- neurosciences,
- emergency medicine,
- paediatrics,
- and some surgical specialties.

It is important to note that some of these areas are involved in long-standing formal processes, therefore the strong and challenging feedback about the culture of speaking up is unsurprising.

Some participants talked about a lack of anonymous options to speak up or raise concerns. Whether it be submitting incident or Datix forms or having discussions with colleagues, being identifiable was a key barrier. Participants also highlighted uncertainty about the role of Freedom to Speak Up, the powers of different escalation routes and whether neutral support genuinely exists.

Some talked about taking concerns to MDT meetings to raise concerns collectively, therefore reducing the impact on them as an individual.
Some noted that speaking up was easier within trusted local teams and departments, than within the wider organisation. This explored further in section 5.8 - surfacing best practice.

> I'd like to feel that “speaking up” and “whistleblowing” doesn't carry any negativity – Interviewee 006

> Unfortunately, most (if not all) of the consultants who have tried tackle patient safety issues have either been sacked, forced to move on…investigated for so long that they have forgotten their own names, or in the majority of cases just given up - Survey respondent

5.1.2 Futility and learned disengagement

One of the most universal themes across qualitative and quantitative data was a perception that raising concerns does not lead to change.

> **I have no difficulty speaking up but have given up because nothing changes. It's not a belief, it's reality - Survey respondent**

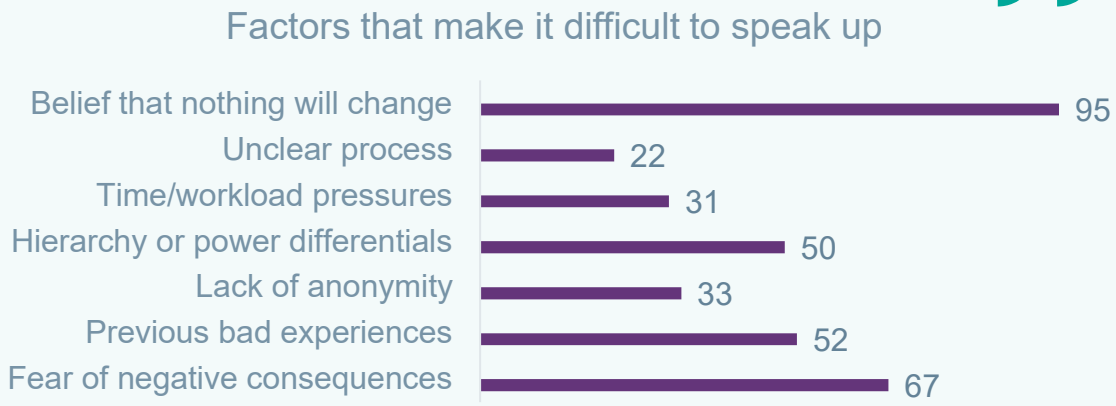

Figure 3: Barriers to speaking up

Participants reported that concerns often disappear into systems without meaningful follow-up – leading to a belief that speaking up is futile. This was especially important because many participants still *wanted* to engage — they had simply lost confidence that engagement would make a difference.

Common statements included:

- "nothing happens",
- "radio silence",
- "black hole",
- and "ghosted".

Several participants described reducing their use of Datix or formal escalation systems because of low confidence in organisational responsiveness. Many talked about often not even getting a response or acknowledgement when they raised issues.

Others described emotional exhaustion from repeatedly escalating the same issues, which have not been resolved. This exhaustion comes both from the increased admin burden of completing incidence forms or submitting Datix's but also in repeatedly attempting to engage other colleagues (particularly operations colleagues) in helping raise awareness and escalating issues if they are already known.

Many participants described uncertainty about how decisions are made, who is accountable, what happens after escalation and whether concerns are represented accurately as they move upwards.

Participants described withheld minutes, unclear rationale for decisions, concerns being reframed, sanitisation of risk, and messages becoming diluted across governance layers. Several participants stated that in the absence of transparency, gossip, speculation and informal narratives have become the dominant organisational currency.

All of these factors have significantly reduced confidence in formal processes.

5.1.3 Psychologically safe teams

Several participants described their immediate teams positively.

Protective factors included:

- approachable clinical leaders,
- open MDT discussion,
- peer support,
- collaborative problem-solving,
- and respectful challenge.

> The MDT that I'm in is really lovely, so I'm very lucky – Interviewee 003

When looking at how psychological safety varies across divisions:

- It is primarily shaped by local team culture rather than organisational structure. A repeated pattern is that psychological safety is experienced locally, not organisationally.
- Within divisions, experiences are mixed, with some specialties reporting strong confidence to speak up and others describing more cautious or constrained environments. This suggests that specialty/team culture is a stronger driver than division alone.
- Specialties with high workload and operational pressure (e.g. ED, acute, critical care) tend to show more polarised responses, some strong team cohesion and openness, alongside concerns about escalation, hierarchy, and consequences. This likely reflects strong local team reliance but wider systemic pressure affecting confidence.
- Some specialties, including some smaller, report strong internal psychological safety (e.g. palliative medicine team, oncology, paediatric sub-specialty teams and infectious diseases) but less confidence in escalating beyond a team levels - as a direct result of previous experience of escalating.

> Within our team, we have implemented psychological safety principles, which are now a core part of our practice. This has been helpful in promoting open discussions without hierarchy, where everyone's views are heard and respected.... open, accessible discussion is important-including the option for one-to-one conversations and anonymity where appropriate-this is not consistently reflected beyond team level - Survey respondent

5.1.4 Influence of hierarchy and status on psychological safety

Participants repeatedly described hierarchy as shaping whether staff feel safe to speak, with managerial relationships being the strongest influencing factor.

This indicates that day-to-day relationships with leaders are the most significant determinant of whether staff feel included or able to contribute.

Figure 4 summarises survey findings, which closely align with the key themes raised in our qualitative data.

Several consultants acknowledged they personally felt able to raise concerns, influenced by a combination of factors, including gender, length of time within the service or their employment status. While SAS doctors and internationally trained consultants were perceived as less likely to feel comfortable speaking up or being heard.

Consultant and SAS doctors repeatedly described junior doctors and nurses as reluctant to exception report, challenge consultants, or escalate concerns because of perceived career risks. Direct engagement with these staff cohorts is needed to corroborate this finding.

In respect of other characteristics, participants also highlighted differential experiences of psychological safety based on seniority, specialty, ethnicity, communication style and cultural background. For example, some internationally trained staff and staff from diverse cultural backgrounds described their more direct communication styles being interpreted as confrontation or aggression – the perception being that, as a result, they were less likely to be heard. Other issues raised were from those in part-time or locum roles around a perceived fear of job security.

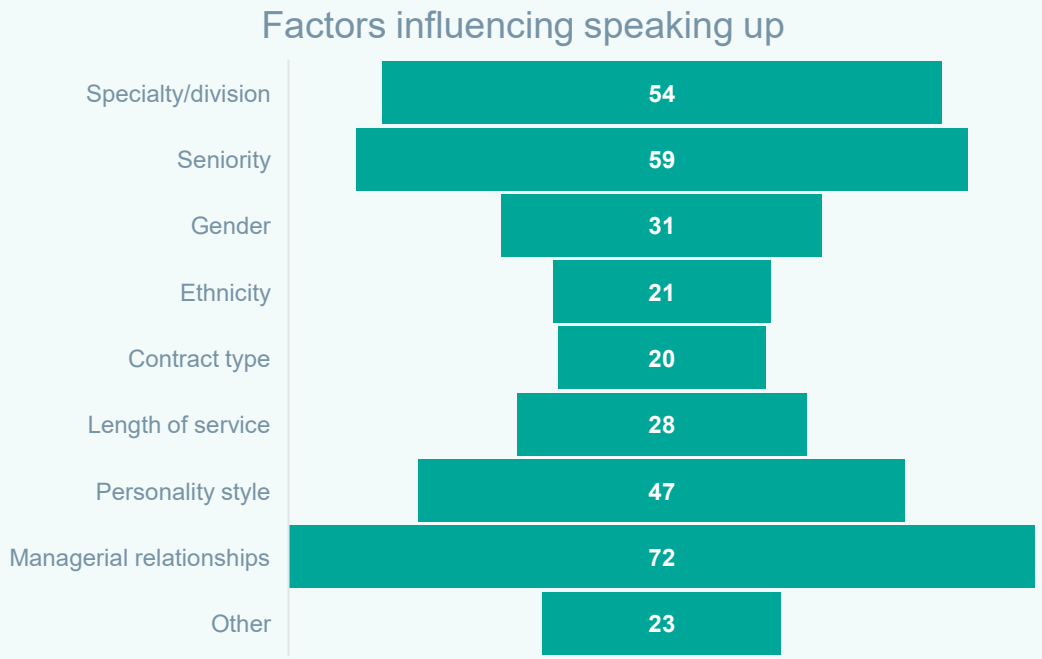

Figure 4: Factors influencing speaking up

5.1.5 Influence of organisational strategy on psychological safety

Participants frequently linked deteriorating psychological safety with systemic workforce shortages, burnout, corridor care, service targets and on-going investigations/patient safety issues. The perception being these issues are never resolved and, worse, have become normalised.

Several participants described environments where people were emotionally depleted, conflict increased and staff became less receptive to challenge.

This created barriers to speaking up because staff increasingly perceived:
- risk as inevitable,
- concerns as already known,
- and escalation as unlikely to change systemic pressure.

Some participants described “picking battles” because the scale of operational challenge felt overwhelming.

Most participants supported service improvement and transformation in principle. However, many stated that change processes are undermined where:
- consultation is limited,
- clinicians are not meaningfully involved,
- rationale is unclear,
- or changes appear financially rather than clinically driven.

Participants universally emphasised the importance of visibility, communication, discussion and genuine engagement before change implementation.

Some participants described a significant lack of confidence in informal and formal investigation routes.

Concerns from those with direct experience of being involved in such processes included:
- investigations beginning conducted without full information,
- not speaking to the right people,
- excessive timescales which breached policy guidelines,
- poor communication,
- and inconsistent implementation of recommendations.

Observers of these processes also described investigations lacking neutrality, and disproportionate responses.

A particularly important finding was that participants often perceived relationship issues, behavioural concerns, or safety concerns sometimes being reframed into interpersonal disputes rather than the substantive organisational problems that were reported.

This reduced trust that speaking up would lead to fair resolution.

> Seems to be no consequence at all to even something that the trust must have deemed serious enough to spend quite a lot of money into investigating – Interviewee 005

> What makes it difficult is that the people you're complaining about are also involved in the hierarchy of the thing – Interviewee 039

Transformation Partners in Health and Care

Section 5.2 Representation, credibility and fairness of voice

A strong perception emerged that influence and credibility are not distributed equally across the organisation – *identifying a range of roles and equalities characteristics which feel less heard.*

Participants repeatedly described informal hierarchies and differences in whose concerns receive attention.

Participants identified examples where diverse perspectives are actively encouraged and different professional viewpoints are valued.

Positive examples included:

- *smaller specialist teams with flatter hierarchies,*
- *MDT forums that enable collective discussion and challenge,*
- *leaders who actively seek views from quieter individuals,*
- *teams where contribution is valued based on expertise rather than status,*
- *collaborative environments where consultants, SAS doctors and multidisciplinary colleagues contribute equally.*

These examples demonstrate that inclusive approaches to participation already exist within parts of the organisation.

5.2.1 Where influence sits within the organisation

Many participants described influence, and those who are most heard within the organisation, as being shaped by established status and proximity to existing power structures.

Participants perceived that individuals were more likely to be heard, promoted or influential where they were:

- professionally well-connected,
- long-standing members of the organisation,
- trained internally,
- senior in status,
- part of high-profile specialties,
- White,
- male,
- or already closely connected to leadership networks.

Several participants referred, historically, to “inner groups”, “favoured people” or informal power structures, describing a perception that the same voices and perspectives are consistently prioritised. Primarily this was by the previous CMO office and Medical Staffing. Participants felt this created inequity in whose views carry weight and contributed to perceptions of bias within organisational decision-making.

Some participants concluded that these dynamics contribute to the organisation being perceived as relatively insular, with influence concentrated among established or connected groups. This was felt to create a divide between those who are able to shape decisions and those who feel excluded from influence or overlooked.

Participants also described variation in influence between specialties. Some felt that departments associated with income generation, operational performance targets or organisational visibility had more leverage. For example, it was felt specialties like Emergency Medicine and Neurosciences were more likely to receive attention, resource and responsiveness.

In contrast, smaller or highly specialised services were described as more likely to feel overlooked, dismissed or deprioritised, contributing to frustration and disengagement – for example, paediatrics and women's health.

> Where there is financial benefits – their voices are heard well and get the things they request for. Block contract – more activity does not make the Trust any more money so are not interested in the team – Interviewee 031

> Certain teams can raise whatever they want, whether it is truthful or not, and it then directs the responses of the organisation to patient safety, behaviour, and professional standards concerns. These teams can raise concerns early (prophylactically,actually). The issue is the imbalance of power, preferential treatment, prejudice, predetermination, and victimisation all acting in concert within the patient safety framework - Survey respondent

5.2.1 Where influence sits within the organisation

Going further, some participants linked these dynamics to the characteristics of those appointed into leadership positions. Several participants perceived a lack of diversity within leadership, both demographically and in terms of diversity of thought, communication style and professional background. - across all leadership levels within the organisation.

Participants described leadership cultures as relatively homogeneous, with limited openness to alternative perspectives or external learning.

Participants repeatedly linked this to wider organisational impacts, including:

- reduced constructive challenge,
- reinforcement of existing power dynamics,
- Group think and an inability to learn from external best-practice,
- reduced innovation,
- and missed opportunities to learn from different experiences and approaches.

Several participants explicitly advocated for the organisation to place greater emphasis on celebrating difference and creating more inclusive approaches to communication, leadership, participation and decision-making. There was recognition of recent senior leadership changes and efforts to turn the tide on previous attitudes and practice.

> We have one of the least diverse senior leadership/ boards. An issue in other divisional leadership roles as well. Not given encouragement to go into those leadership roles. Not sure if this a racial thing, but favouritism. A lack of diversity of thinking among leadership. All leaders think the same which is not good. We are creating more people the same – Interviewee 026

5.2.2 Differential experiences of speaking up

Those who are least heard in the organisation tend to fall into predictable, and well known, categories. Figure 5 summarises staffing groups perceived to be less likely to speak up.

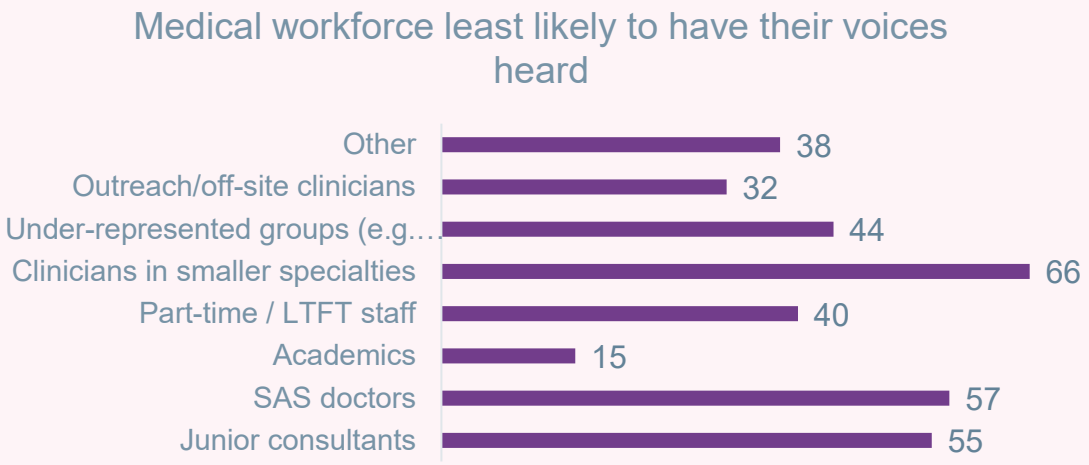

Figure 5: Staffing groups less likely to speak up

Outreach/ off-site clinicians and part time LTFT staff

Several participants raised concerns that key department/division and organisations meetings are held at times and, in locations, that make it difficult for these staff groups to be involved – reinforcing the perception that only certain groups of consultant staff are listened to and have influence.

Clinicians in smaller specialities

Experiences here were not universal. Consultants from smaller specialties where they felt they were less "high profile" such as palliative care, were more likely to feel less heard. However, consultants in low volume/high specialty areas were more likely to feel heard.

Academic Consultants

Qualitative findings showed that most Academic Consultants felt more confident speaking up because of their employment status and not directly or wholly being employed by CUH.

SAS doctors

A consistent theme was that SAS doctors are perceived to have:

- less influence,
- reduced visibility,
- and lower psychological safety.

Several participants specifically contrasted consultant voice with SAS doctor voice.

Staff groups identified by consultants and SAS doctors

Due to the transient nature of junior doctors, Consultants felt this group were less likely to speak up and be heard because of impacts on future job prospects, lack of organisational familarity and observation of organisational culture.

Several participants described Nursing staff as less likely to escalate concerns and be less influential, with participants recognising divisions between medical and Nursing cultures and associated leadership structures.

It will be organisationally important to understand experiences directly from these staff groups to corroborate findings.

The “other” responses reinforced ethnicity, gender, disability and “favoured groups” as factors affecting whether voices are heard. These under-represented groups will be discussed further in section 5.6.

5.2.3 Encouraging lesser heard voices to contribute

Data points to several key factors that would encourage lesser heard voices to contribute, but visible action and follow-through is the single most important factor.

As mentioned previously, many participants described disengagement, not because people had nothing to say, but because they believed concerns disappear, nothing changes or feedback is not acknowledged. Though primarily historic experience, a proportion of this feedback also related to current feelings and attitudes.

For lesser-heard groups especially, repeated experiences of inaction appeared to reinforce beliefs that their views carry less weight, escalation is risky and participation is performative.

Figure 6 summarises survey findings, which closely align with feedback from qualitative data.

Figure 6: Encouraging lesser- heard voices to contribute

Many participants described needing independent, neutral and psychologically safe routes to feedback. This was particularly important where the concern involved senior individuals and local leadership as well as the person concerns would normally need to be escalated to.

Several participants explicitly asked for forums where already-raised concerns could continue to be explored and stronger support for staff who struggle to articulate concerns confidently themselves. There was recognition that some existing forums such as the consultant forum do not provide this.

A recurring finding was that the organisation often consults those in clinical leadership positions, which felt somewhat appropriate. However, it was felt that prioritising individuals who are already visible over a more representative and diverse group of consultants and SAS doctors was problematic.

Many participants felt lesser-heard voices would contribute more if these dynamics shifted to extend beyond formal leadership roles, including wider multidisciplinary teams, and creating multiple participation options in to support those groups of staff outlined in sections 5.2.2 and 5.8.

Participants consistently described the kinds of behaviours they were looking to see from leadership:

- dealing with issues early,
- being open about decision-making processes,
- inviting challenge,
- responding non-defensively,
- acknowledging uncertainty and unresolved risks,
- listening visibly,
- treating feedback constructively,

5.2.3 Encouraging lesser heard voices to contribute (continued)

- actively recognising differential safety,
- acknowledging power dynamics,
- and addressing inequities in influence.

This means leadership response becomes culturally symbolic.

Representation and credibility of voice are currently experienced more through local leadership and culture than through organisation-wide structures. Supportive local leadership was not concentrated in one division which bodes well for the organisation as a whole.

Several suggested that lesser-heard voices are contributing more where leaders spend time in clinical areas, engage directly and build familiarity and trust over time. Participants described safer environments where leaders were visible, teams knew each other and where there was ongoing dialogue rather than episodic consultation. This tended to be more apparent in smaller specialist services.

Positive MDT cultures emerged in several clinical areas, used as places where concerns could be raised collectively rather than individually – building confidence.

These themes are discussed further in section 5.8 - surfacing best practice.

Suggested enablers to embed changes to the culture included offering mentorship, structured feedback training and setting clearer behavioural expectations.

Transformation Partners in Health and Care

Section 5.3

Risk, early warning and organisational intelligence

Participants consistently described significant organisational intelligence about risks already existing within the system *and, in the majority of cases, understanding the key processes and escalation routes to raise concerns.*

However, the dominant concern was not inability to identify risk, but the organisations inability to respond effectively and visibly.

Participants demonstrated strong awareness of risk and a clear commitment to patient safety.

Positive examples included:

- *active use of Datix, governance and escalation processes,*
- *clinicians identifying and escalating concerns early,*
- *strong MDT discussions of clinical risk,*
- *local leaders who encourage proactive risk identification,*
- *examples of risks being addressed successfully through collaborative problem-solving.*

The listening exercise found no shortage of willingness amongst clinicians to identify concerns and raise emerging risks.

5.3.1 Risk and concern logging processes

The vast majority of consultants and SAS doctors know how to raise concerns and risks, both informally and formally. However, participants questioned the effectiveness of these processes.

Concerns are most commonly raised informally and locally (as demonstrated in Figure 7), with consultants relying on trusted relationships - rather than formal escalation routes, even in more serious scenarios.

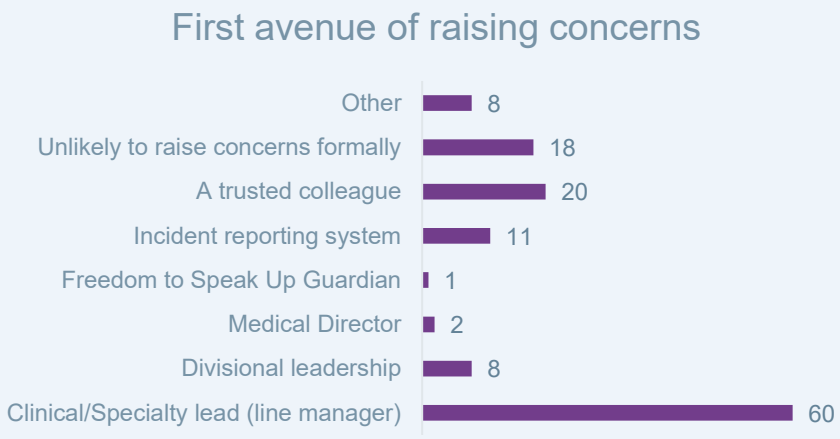

Figure 7: First avenue of raising concerns

While escalation to more formal routes increases with the severity of the issue, reliance on these pathways remains limited. A notable proportion of participants indicate reluctance to raise concerns formally (illustrated in Figure 9), highlighting a gap in confidence in organisational processes, due to futility and a perception of how the concern will be dealt with (Figure 8)

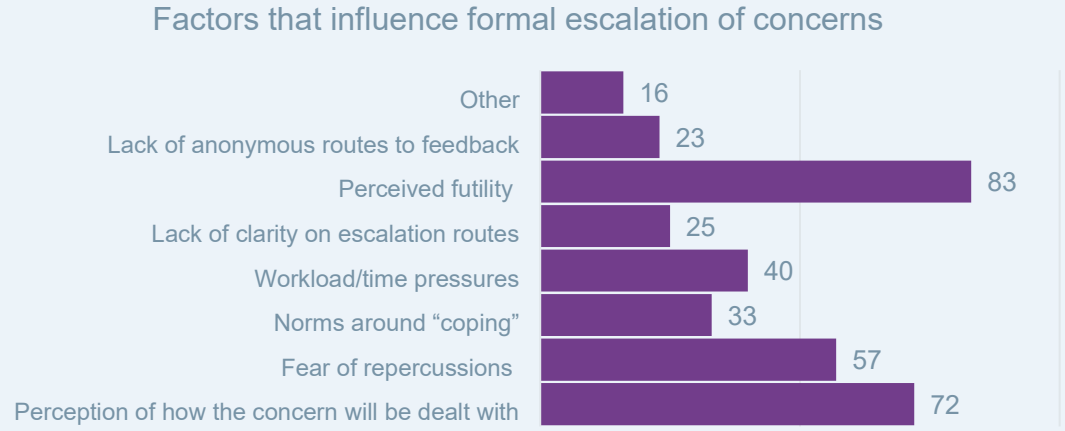

Figure 8: Factors influencing formal escalation of concerns

While some consultants and SAS doctors move to more formal routes, if initial escalation is unsuccessful, a significant proportion report that they would not escalate concerns further (Figure 9). As the majority of participants were reporting to Clinical/Specialty leads in the first instance (Figure 7), this indicates a drop-off in confidence beyond first-line escalation. This resonates with wider themes about powers given to these roles in resolving and escalating issues.

A few participants confessed they did not know the thresholds for raising concerns and formally escalating, advocating for clearer information on this.

5.3.1 Risk and concern logging processes

Figure 9 summarises survey findings, focused on where consultants and SAS doctors go if their first attempt to raise concerns is not successful or satisfactory. Here we see an increase in the proportion of respondents who would contact the Freedom to Speak Up Guardian, divisional leadership or the CMO, compared with findings in Figure 7 . We also see an increase in the proportion who would be unlikely to take the concern forward.

This data aligns with qualitative findings.

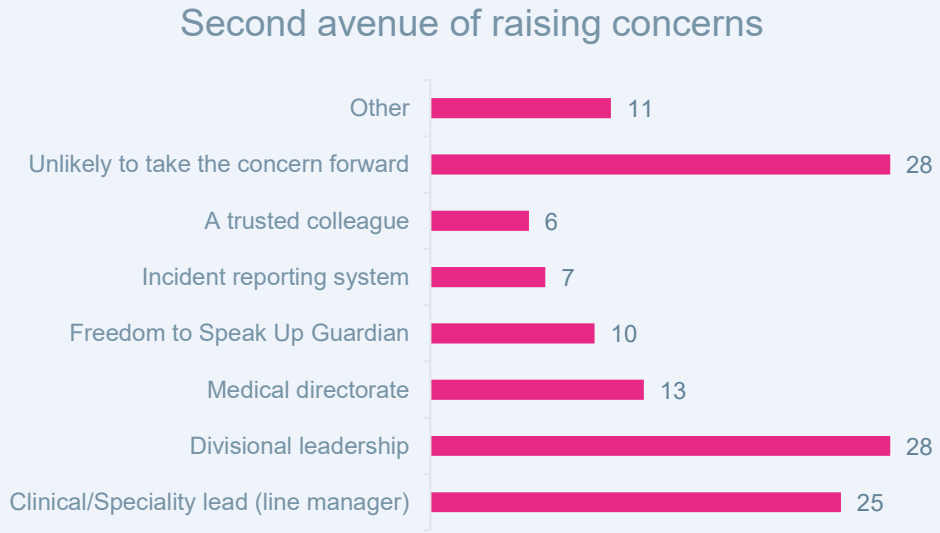

Figure 9: First avenue of raising concerns

Escalation is seen as higher effort, complex and having an increasing risk of exposure, alongside low confidence that leadership, at any level, will act.

While most consultants and SAS doctors are raising concerns (74% of survey participants), over a quarter (of survey participants) choose not to raise concerns in some situations, depicted in Figure 10. These trends align with qualitative findings.

Figure 10: Action taken once concerns are identified

When asked about raising concerns as a bystander, the majority of survey participants indicate they would be likely to raise concerns as a bystander (74% very or quite likely). Just under a quarter (approximately 22%) report that they would be unlikely to do so. This highlights variation not only in personal experience of speaking up, but also in willingness to intervene when concerns are observed.

5.3.1 Risk and concern logging processes (continued)

Participants spoke at length about their experiences of reporting risks and concerns via admin processes such as Datix's and risk registers. Most participants described flaws with both processes.

> We treat the data rather than the incident. And that means minimizing the work that comes out of an incident being reported – Interviewee 034

Whilst most continue to complete Datix's there is a generalised fatigue with the process, due to a lack of acknowledgement that feedback is received and lack of response – commenting that the process feels passive. This perpetuated feelings of being unheard, linked to findings in section 5.1.2. Some participants noted challenges with the actual system itself – such as available categories to select to properly categorise the concern as well as the distribution list post-submission. Some talked through Datix's being sent to people not involved in the incident or in a handful of cases, sent directly to the person being reported in the Datix – reducing psychological safety.

> I had to used Datix to report a traumatic incident that happened to me, personally. It was then shared, via the system, with lots and lots of people. Many of whom it didn't appear relevant to and I didn't know. The system feels it's there as a "record of the right thing being done, rather than doing the right thing"– Interviewee 016

Some talked about a lack of a strategic approach to Datix's and being unclear whether they were reviewed alongside other submissions to understand themes and patterns, which could meaningfully lead to organisational learning.

In terms of risk registers, the vast majority of participants knew these existed, however many were unclear about how these were managed and what actions led on from these documents. Some participants viewed risk registers as the only mechanism capable of generating traction, but this was still variable across divisions.

Participants repeatedly questioned whether senior leaders can accurately see patterns, hear cumulative signals, or understand frontline experiences – based on information and data provided to them.

Several described concerns becoming fragmented across committees, governance structures and operational layers, which either dilute or block concerns from being presented accurately to senior leaders and the Board.

5.3.1 Risk and concern logging processes (continued)

Participants felt to be more willing to speak up where leaders, no matter their position in the organisation, are visible, approachable and trusted, and where there are independent or psychologically safe routes for discussing concerns before issues escalate formally.

Overall, the findings suggest that earlier escalation is where the organisation can best reduce fear, increase trust and create cultures in which speaking up is experienced as both safe and worthwhile.

> Having a sort of very safe appeal pathway whereby if it's blocked at one level you can appeal via a different route so you're not going back to the same people. Because I think that's part of the problem is you have to resubmit it to the same committees – Interviewee 027

5.3.2 Repeated escalation of longstanding concerns

Many participants described concerns being escalated repeatedly over prolonged periods of time and therefore being known to the organisation. This reinforces the notion that, if concerns and risks are raised, nothing happens or changes.

Examples included:

- workforce shortages,
- unsafe rotas,
- operational pressure,
- digital safety risks,
- clinic access concerns,
- waiting room risks,
- and infrastructure limitations.

Several participants described concerns remaining unresolved despite using proper channels such as:

- Datix reporting,
- risk registers,
- governance meetings,
- external reviews,
- and repeated escalation to senior leadership.

In addition to creating disengagement, many participants talked about the moral injury felt by having done the right thing, but being left, often without proper support, to manage the repercussion of these concerns and risks.

> It is harder to speak up when previous concerns have not been met with clear, timely engagement from senior leadership which reduces confidence that raising concerns will be meaningfully supported - Survey respondent

5.3.3 Workforce and staffing challenges

Most participants raised workforce pressure as a major operational and cultural risk. This sits alongside consultant and SAS doctors continuing to deliver safe services that meet the needs of their patients.

Participants described:

- chronic understaffing,
- burnout,
- rota fragility,
- delayed recruitment,
- lack of middle grades,
- middle management (Clinical Leads/Clinical Directors/ Divisional Directors) without proper training and support to be effective in their leadership roles,
- and reliance on goodwill.

Participants also raised concerns regarding:

- lack of succession planning,
- removal of admin staff which increases admin burden on consultant and SAS doctors,
- insufficient planning when activity transfers between services,
- insufficient planning when specialised services from other areas are absorbed into the Trust,
- and clinicians having to normalise unsafe workarounds to maintain patient care.

Many participants explicitly stated that goodwill is currently holding teams together and described the emotional exhaustion associated with repeatedly compensating for workforce gaps.

> Individuals take on a lot of guilt/apologising/mitigating with patients and manage multiple complaints. I often take this home to respond/resolve so it doesn't impact clinical care but it impacts my personal life – Interviewee 007

Several participants described corridor care, lack of emergency theatre capacity and prolonged operational pressure becoming normalised despite being viewed as unacceptable.

A recurring concern was that operational and financial priorities were perceived to outweigh clinical judgement with a perceived loss of clinical input to decision-making.

Some participants specifically questioned whether non-clinical operational leaders should be involved in decisions relating to clinical safety, pathways or service configuration without stronger clinical accountability.

Particular concerns were raised in:

- emergency medicine,
- paediatrics,
- oncology,
- anaesthetics,
- and some specialist services.

5.3.4 Digital and operational safety risks

Some participants described concerns that digital or automated processes can unintentionally reduce safety, increase workload and be ineffective in supporting clinical care.

This was particularly the case where systems are:
- inflexible,
- poorly integrated,
- or not sufficiently designed around clinical workflows.

Examples included:
- prescribing system concerns,
- outpatient automation issues leading to missed or incorrect communications,
- the creation of mix ups in labs,
- and vulnerable patients struggling with digital access routes.

A few participations also spoke about the prioritisation of strategic digital projects (like surgery robots and digital ward boards) at the expense of dealing with "basic" operational issues.

> Pet projects get prioritised like robots doing surgery rather than dealing with urgent staffing issues. Children's hospital is great but won't benefit as many people as they think it will. Transformation schemes not as well thought through as they could be – Interviewee 004

Many participants described frustration that clinicians are not always meaningfully involved in service redesign, operational decision-making, pathway changes, strategy or digital transformation. This has led to safety and quality issues and the perception that resources have, in some circumstances, been wasted.

Several participants questioned whether non-clinical operations leads and finance teams fully understand the downstream clinical implications of decisions.

This was particularly strong where participants felt:
- decisions were financially driven,
- consultation was limited,
- or rationale was poorly communicated.

> I've never had a meeting with the Investment Committee before. But the way that that meeting went, it kind of was an insight into the lack of clinical understanding at that level – Interviewee 045

Transformation Partners in Health and Care

Section 5.4

Learning, prioritisation and visible ownership

The strongest organisational criticism related to visible ownership and follow-through.

Participants consistently described concerns being acknowledged but not translated into visible change.

Participants highlighted examples where concerns are translated into action through clear leadership ownership and collaborative working.

Examples included:

- *operational managers working alongside clinicians to solve problems,*
- *teams that regularly review concerns and progress actions,*
- *services sharing learning across specialties,*
- *leaders who provide updates on actions taken,*
- *examples where local ownership has led to tangible service improvements.*

These examples demonstrate the value of visible leadership and clear accountability.

5.4.1 Process once concerns are raised

The vast majority of participants perceived "nothing" had happened once concerns were raised, due to a lack of feedback – both in relation to issues they had raised themselves or influenced by experiences of colleagues. Some discussed feeling that someone, somewhere, was reviewing information shared and taking action, however, when prompted, this was not an evidence-based belief.

A major recurring theme was fatigue associated with listening exercises, reviews, investigations and governance processes - without visible implementation.

Many participants felt the process following escalation was inconsistent, opaque and emotionally difficult to navigate. A recurring theme was that concerns often enter formal systems — such as Datix, governance structures, HR processes or investigations — but staff then experience very limited visibility of what happens next, contributing to frustration, distrust and disengagement over time.

Many stated that they understood issues could not always be resolved quickly, but the absence of transparent communication significantly undermined confidence in the process – both in relation to historic and more recent issues raised.

Participants also described concerns about the nature and fairness of investigation processes once concerns had been raised.

Some felt investigations could become overly focused on interpersonal dynamics, behavioural framing or organisational risk management, rather than the underlying patient safety, workforce or systemic issue being raised.

Several participants described situations where concerns about clinical practice or safety were reframed as “relationship issues”, leading staff to feel the substantive concern itself became diluted or deprioritised.

Some participants also described investigations as:

- excessively prolonged,
- lacking neutrality,
- inconsistently applied,
- or insufficiently evidence-based.

Some of these findings were in relation to historic investigations, with a few related to more recent experiences. Specific concerns included not speaking to the right individuals, bringing additional people into meetings unexpectedly, inconsistent implementation of recommendations, breaches of organisational timelines or policies and lack of follow-up after investigations concluded.

> “It's just such a slow and long-winded process, which seems more dedicated to protect the person that was bullying than the people who were bullied, if that makes sense – Interviewee 039

> Unprepared to deal with clinical competence issues and these are badged as “relationship issues” and swept under the carpet – Interviewee 010”

5.4.1 Process once concerns are raised (continued)

Several participants felt there was inconsistency in organisational response, with some behaviours tolerated over prolonged periods, while more minor issues could trigger disproportionately formal processes.

> Processes [following incidents] change constantly. I do 2-3 shifts a month and there is always a new process when I return. It's a sign of a failing department – Interviewee 010

Several participants also described uncertainty regarding the role of Medical Staffing, HR, unions and Freedom to Speak Up, including whether these routes were sufficiently independent, empowered or supportive.

When responses were received, often these were perceived as tick box and avoidant.

Many participants described prolonged delays in being able to recruit, make operational decisions, undertake service redesign and implement decisions. Several participants felt operational structures had become overly layered, risk averse slow and deliberatively divisive.

Another strong theme was the emotional and professional impact of raising concerns. Some participants described becoming isolated, withdrawing from leadership roles, “picking battles” or reducing future escalation because of previous experiences with organisational processes. Others described relying on collective escalation through MDT groups or peer backing because raising concerns individually felt too risky.

Despite this, participants were generally not arguing against the value of governance or investigation processes themselves. Rather, they repeatedly called for processes that are:

- more transparent,
- proportionate,
- timely,
- relational,
- restorative,
- and visibly linked to learning and improvement.

Participants were clear that they now would expect continued listening, paired with action that includes timelines, accountability and communication.

5.4.2 Prioritisation of issues

Participants generally understood resource limitations and therefore the need to prioritise concerns. However, there were mixed views on whether or not the organisation has, historically, gotten this right.

Participants repeatedly stated that trust would improve if leaders, at all levels in the organisation:

- explained decisions,
- communicated priorities,
- acknowledged unresolved risks,
- and openly described constraints.

Several participants contrasted silence negatively against transparent acknowledgement.

Many raised the differential accountabilities. Participants described remaining professionally accountable for patient outcomes, complaints and regulatory responsibilities, even where the risks arose from operational, financial or strategic decisions outside their control. Examples included workforce shortages, rota gaps, service reconfiguration, capacity pressures, digital system issues and longstanding operational risks such as corridor care. Participants frequently described escalating these concerns through appropriate channels but felt that accountability for managing the consequences remained with frontline clinicians rather than those responsible for organisational decision-making.

Data from all engagement methods demonstrates participants feel that important issues are sometimes underestimated by both clinical (for 73% of survey respondents – Figure 11) and non-clinical leadership (for 83% of survey respondents – Figure 12). This perception is more pronounced for non-clinical leadership, where concern is both higher and more consistently expressed across participants.

Significant feedback was received about the role of operations in managing the prioritisation of clinical concerns – and about whether this was appropriate. Feedback also discussed a general feeling that support from operations is lacking, with dialogue overly focused on performance.

Figure 11: Clinical leadership: understanding of important issues

5.4.2 Prioritisation of issues (continued)

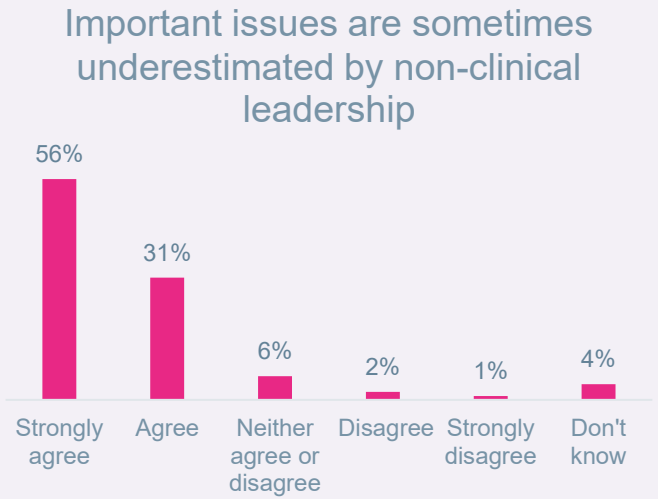

Figure 12: Non-clinical leadership: understanding of important issues

Many participants described concern that organisational prioritisation is perceived to be driven more strongly by operational, financial and reputational pressures than by frontline clinical experience.

Participants frequently referred to performance targets, flow pressures and organisational visibility influencing which issues receive attention, resource or urgency. Some questioned whether issues are sometimes prioritised according to the level of organisational risk posed to the Trust itself, rather than the cumulative impact on patient care, workforce wellbeing or long-term service sustainability. This hints at a perception that there is a separation between the Trust and the consultant and SAS doctor workforce in terms of priorities and focus.

Several participants also described variation in how different specialties experience organisational responsiveness. Smaller or highly specialised services often felt less able to compete for attention, resource or investment compared with larger services associated with operational performance targets or organisational visibility. Participants linked this to wider perceptions of inequity in influence and organisational voice, discussed in sections 5.2.2 and 5.6.1.

As previously discussed, a recurring concern was the normalisation of operational risk, including corridor care, chronic staffing pressures and sustained reliance on workforce goodwill. Some participants felt that once risks become longstanding and routine, they lose organisational urgency despite continuing frontline impact.

> Sometimes the best thing you can do for a pathway is let it go wrong – Interviewee 034

Several participants described concerns, improvement proposals and service changes entering governance or transformation processes but failing to progress into visible implementation. Participants frequently described actions stalling after initial discussion, becoming diluted through organisational layers or remaining unresolved despite appearing within formal governance structures. This contributed to a perception that the organisation is often stronger at initiating change than sustaining delivery and follow-through.

5.4.3 Ownership of actions

Many participants described uncertainty about who owns problems, who can make decisions and who is accountable for delivery.

Participants frequently described concerns moving through systems without clear responsibility.

Many participants also described middle management structures (Clinical Leads/ Specialty Leads/ Clinical Directors/ Divisional Directors) as ineffective or insufficiently empowered.

> Middle management is a fool's game in many ways, there are challenges coming from the bottom and challenges coming from the top, and you have very little power to make decisions on your own – Interviewee 003

Participants repeatedly stated that concerns escalate upwards but do not return with resolution. Middle managers often appear unclear about what happens after escalation, therefore accountability becomes diffused across governance layers.

Several participants questioned whether senior leadership are sufficiently prepared to make difficult decisions where there may be reputational, workforce or operational consequences – particularly in relation to conduct issues during informal and formal investigation processes.

Clinical leaders were frequently described as lacking:

- protected time,
- training,
- mentorship,
- administrative support,
- or authority.

Some participants described clinical leadership roles as structurally difficult because individuals are managing peers while simultaneously balancing operational and clinical pressures.

Many participants also described uncertainty regarding where accountability ultimately sits when concerns span multiple teams, Divisions or governance structures. Several participants described concerns entering systems (like Datix) but no individual or group appearing clearly responsible for driving resolution, maintaining oversight or noticing themes or patterns – which creates more organisational risk.

> If you get one incident, that's the tip of the iceberg. There are nine others that haven't been reported because people are busy, or they've got other stuff to do. The fact it gets taken off a serious incident investigation pathway because no one was actually harmed is utterly wrong to me. If someone had got harmed two weeks later, you'd be indefensible– Interviewee 034

5.4.3 Ownership of actions (continued)

Several participants also linked unclear ownership to broader organisational fragmentation. Participants described the current structure of Divisions, complex governance pathways and limited cross-organisational visibility as barriers to coordinated action and learning. Some participants felt this contributes to repeated concerns, duplication of discussions and difficulty maintaining clarity regarding responsibility and decision-making.

A recurring concern was the perceived inconsistency between accountability for frontline staff and accountability for organisational decision-making – also referenced in section 5.4.1**.** Many participants reflected that clinicians continue to hold professional and regulatory accountability for patient outcomes, while the operational, financial or strategic decisions shaping those risks may sit elsewhere. Some participants questioned whether senior leaders are always sufficiently accountable for the longer-term consequences of organisational decisions, particularly where risks become normalised over time.

> If you are going to make a decision but you're not going to support something that clinicians have told you is critical, you have to accept that you are then taking responsibility for that and actually making the people who are doing those decisions justify from a safety perspective why they are saying that – Interviewee 027

Transformation Partners in Health and Care

Section 5.5

Follow-through, trust and confidence

Trust in organisational responsiveness was generally low to moderate.

Participants commonly described confidence being shaped primarily by whether action is visible, whether communication is transparent and whether leaders appear willing to address difficult issues.

Participants consistently described trust increasing when concerns receive visible acknowledgement and response.

Positive examples included:

- *leaders who communicate progress regularly,*
- *feedback being provided to those raising concerns,*
- *teams where actions and timelines are clearly explained,*
- *services that openly discuss unresolved risks,*
- *examples where staff can see a direct link between feedback and change.*

Participants repeatedly stated that even difficult decisions are easier to accept when the rationale is communicated transparently.

5.5.1 Visible follow-through

Visible follow-through emerged as one of the strongest determinants of trust, engagement and psychological safety.

Many participants described the issue not simply as whether action happens, but whether staff can *see* that concerns are being acknowledged, progressed and owned over time – discussed in section 5.4.2.

Many participants emphasised that visible follow-through does not necessarily mean every concern can be fully resolved. Participants were generally realistic about operational, financial and workforce constraints. However, they consistently stated that trust improves where organisations communicate openly about:

- what can and cannot be addressed,
- why certain decisions have been made,
- what progress is underway,
- and where risks remain unresolved.

Several participants also highlighted the importance of closing feedback loops with the original reporters, including testing proposed actions with those who raised concerns and providing updates after investigations, governance discussions or service reviews. They also highlighted balancing positive stories with challenges so that this process feels genuine.

> “We have quite a lot of chirpy feedback in terms of, oh, look at this good thing happened or this new service that's being instigated. But what about the thorny issue, which is unresolved? What about outcomes on that? Interviewee 003”

Participants described visible follow-through as particularly important for demonstrating that speaking up is worthwhile and that organisational learning is genuinely occurring rather than concerns being managed performatively.

Some participants contrasted examples of visible leadership and responsive problem-solving positively against experiences where actions appeared to stall after initial discussion. Participants particularly valued leaders who:

- communicated regularly,
- remained visible during periods of pressure,
- revisited previously raised concerns,
- and demonstrated sustained ownership rather than episodic responses.

Many participants described the impacts of opaque processes. This included a lack of transparency around:

- investigations,
- governance decisions,
- service redesign,
- escalation outcomes,
- and clinical decision-making.

Common concerns from direct experiences included withholding of minutes or responses (following requests via FOI, Medical Staffing or some governance meetings), lack of consultation with frontline clinicians (mentioned across a number of Divisions and specialties) and uncertainty about how agendas are determined within governance forums – both at divisional and organisational levels.

5.5.1 Visible follow-through (continued)

Several participants stated that organisational silence contributes to a culture where gossip and informal narratives become the dominant source of information.

Some participants described concern that issues are deliberately minimised, kept small or reframed to reduce perceived organisational risk.

Participants repeatedly stated that they would rather receive honest acknowledgement, transparent explanation, and realistic timelines than limited communication.

5.5.2 Confidence in organisational response

Some participants described positive experiences and greater confidence in leadership.

These experiences were often linked this to:

- direct relationships,
- accessible leaders,
- responsiveness,
- and local visibility.

This reinforces the importance of relational leadership within the Trust.

Despite criticism, several participants described hope that increased listening, external scrutiny and newer leadership approaches may create opportunities for improvement. Several participants acknowledged this listening exercise itself as evidence that the organisation is willing to listen to difficult feedback. Even among those who were highly critical of aspects of culture, governance or leadership, there was often recognition that creating opportunities for Consultants to speak openly was a positive step.

For some, this listening exercise represented a chance to surface concerns that had been discussed informally for years but had not previously been examined collectively. Participants expressed hope that bringing together perspectives from across specialties and divisions could help create a more honest organisational conversation about underlying issues.

Several participants recognised recent positive changes in leadership visibility and engagement, particularly where leaders were perceived as being more approachable, collaborative and willing to listen than in the past.

While confidence in follow-through remained mixed, some participants felt there were signs of a shift towards greater openness, transparency and engagement with frontline staff. Participants often distinguished between historical experiences and their perception that newer leaders may be more receptive to challenge and alternative perspectives.

Perhaps most notably, many participants remained highly engaged despite expressing frustration about aspects of organisational culture and decision-making. Throughout the interviews, consultants frequently offered practical suggestions for improvement, identified examples of good practice and demonstrated a strong commitment to improving services for patients and staff.

Participants consistently emphasised that confidence now depends on demonstrable action.

Several participants described disconnects between organisational values, “just culture” messaging and operational reality. This also connected with perceptions about connectivity to, and triangulation with, National Staff Survey (NSS) findings.

Within the survey, we asked a specific question on whether CUH demonstrates the principles of a Just and Learning Culture in practice. Survey responses, outlined in Figure 13, indicates overall low confidence and builds on findings in previous sections around speaking up without fear, addressing unacceptable behaviour and performance and systems being designed to make it easier to do the right thing.

5.5.2 Confidence in organisational response

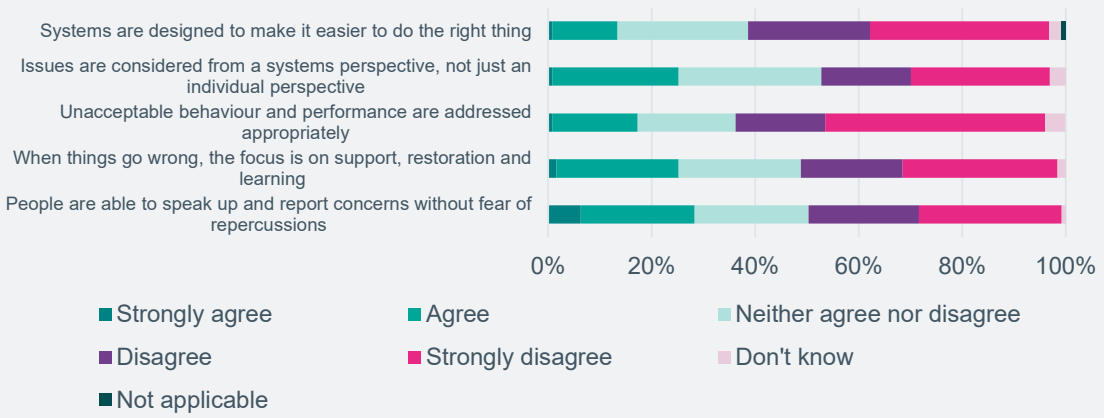

Figure 13: Demonstrating the principles of a Just and Learning Culture

Figure 13 demonstrates that confidence in Just and Learning Culture principles is low, with negative responses outweighing positive across all areas, particularly in accountability and system support. The findings suggest a gap between the organisation's stated commitment to a Just and Learning Culture and staff experience in practice, particularly in relation to accountability, psychological safety, and system effectiveness.

There is also partial recognition of systems thinking, but it is not experienced consistently, with many unsure or unconvinced that a systems approach is applied in practice.

Qualitative findings provide further context – with some participants discussing their views that the organisation does not listen to, or use, NSS data or data from investigations and listening exercises to make meaningful change. Going further, some participants provided examples of when the Trust was actively not living its own organisational values of being Kind, Safe and Excellent – emphasising survey feedback that there is low confidence in the organisations ability to respond appropriately to concerns.

Examples included:

- anti-bullying messages alongside perceived victimisation,
- wellbeing messaging alongside burnout,
- reduced empathy and support for those who have taken time off sick or requiring adjustments to job plans,
- and encouragement to speak up without visible change.

> I don't know what happens to that [NSS]...they ask us all these questions, where does that go? Does it even get read? The qualitative stuff, is that really noticed or taken into account? - Interviewee 003

> Quite a successful hospital in terms of outcomes. In some ways it's more frustrating that positive things are happening in spite of not as well as support from execs - Interviewee 021

Transformation Partners in Health and Care

Section 5.6

Inclusion, belonging and equity of experience

Experiences of inclusion varied considerably across departments and staff groups and included physical inclusion of groups as well as accessibility of ways of working.

Many described inequity in voice, confidence, belonging, and access to influence.

Many participants described strong local team cultures characterised by support, respect and mutual trust.

Examples included:
- *teams with strong peer support networks,*
- *departments that actively welcome new staff,*
- *collaborative multidisciplinary relationships,*
- *leaders who take an interest in staff wellbeing,*
- *environments where challenge and difference are accepted as part of healthy team functioning.*

Participants consistently linked belonging to strong relationships and inclusive leadership.

5.6.1 Inclusion: differential experiences by characteristics

Section 5.2.2. covered differential experience of speaking up by role types. **Feedback also suggested differences in speaking up by different characteristics within the workforce.**

Gender

Gender-related concerns were raised frequently at department and division levels. Themes included:

- women being interrupted, dismissed or excluded from influence,
- misogynistic behaviours,
- differential credibility given to men during investigations relating to bullying, harassment or sexual misconduct,
- and perceptions of historically male-dominated leadership cultures or “old boys’ networks”.

These concerns were especially prominent within:

- neurosciences,
- surgery,
- trauma,
- and some acute specialties.

Several participants also recognised recent improvements in female representation within the Consultant workforce and leadership roles.

> A different way of presenting a problem and that's not as respected...it's more of a collaborative thinking out loud talking that I've noticed with more of the, to be honest, female colleagues. There's some male colleagues also, but predominantly more of a stereotype female way of talking. And I think that's not as respected - Interviewee 039

Neurodiversity, disability and communication differences

Some participants explicitly referenced:

- differing learning styles,
- communication preferences,
- neurodivergence,
- and the need for more inclusive meeting cultures.

Participants recognised that poorly facilitated meetings can disadvantage:

- quieter or more reflective contributors,
- neurodivergent staff,
- and those requiring more processing time before contributing.

Some participants also reflected that staff experiencing burnout, physical illness or mental health difficulties may feel less able to engage confidently in challenge or escalation processes.

> The people in those management roles have been prepared to listen when you're saying something in a very different way....If you look at the middle tier of management in CUH, it is very, very identikit. I don't necessarily mean across all protected characteristics, but I mean across kind of thinking attitude and approach, there's very little embracing and acknowledgement of the huge level of potential benefit that you can get from putting diverse cognitive profiles around the table. And I don't necessarily just mean neurodivergent, I just mean people who approach problems in different ways, people who think a bit creatively, people who take novel approaches, that is not encouraged, that is not supported – Interviewee 027

5.6.1 Inclusion: differential experiences by characteristics (continued)

Personality and communication style

Participants broadly recognised that louder, more assertive or politically confident voices can dominate organisational discussions.

Several participants reflected that organisational cultures can unintentionally favour; confidence in challenge, rapid verbal responses and familiarity with organisational dynamics - while quieter or more reflective communication styles may be overlooked despite valuable insight.

Participants repeatedly emphasised that confidence in speaking should not be conflated with expertise or quality of contribution.

Insider-outsider dynamics

Some participants perceived the organisation as relatively insular, with greater influence afforded to:

- long-standing staff,
- locally trained clinicians,
- and those with established organisational relationships.

Conversely, newer staff or those outside established networks sometimes described themselves as outsiders, or not having the same relational leverage.

Participants linked this to concerns regarding:

- limited diversity of thought,
- groupthink,
- and inequity in whose voices are prioritised.

Primary caregivers and flexibility

Some participants described caring responsibilities as affecting visibility, participation and influence within the organisation.

Participants reflected that those with significant caregiving responsibilities — particularly women — may experience reduced access to:

- informal networking,
- leadership visibility,
- and opportunities occurring outside standard working patterns.

Several participants also described challenges participating in early morning, evening or additional leadership activity, contributing to perceptions that organisational cultures can favour those with greater flexibility and visibility.

Career stage and organisational status

Some participants described differential confidence in speaking up depending on:

- career stage,
- organisational seniority,
- tenure within the Trust,
- and proximity to established networks.

Newer consultants, resident doctors, internationally recruited staff and those less connected to existing power structures were often described as feeling less safe to challenge decisions or escalate concerns independently.

Several participants linked this to:

- fear of reputational damage,
- dependence on progression opportunities,
- and uncertainty regarding organisational culture.

5.6.1 Inclusion: differential experiences by characteristics (continued)

Global majority and internationally trained staff

Several participants described experiences of:

- racism,
- microaggressions,
- exclusion,
- or inequity in how concerns are received and responded to.

Participants also described cultural differences in communication style being interpreted negatively, particularly where directness or honesty was perceived as confrontation.

Internationally trained staff were often described as less likely to escalate concerns because of:

- hierarchy,
- visa dependency,
- professional insecurity,
- unfamiliarity with systems,
- or perceived lack of influence within established networks.

> It is important to recognise that individuals from different ethnic minority backgrounds or cultural contexts may communicate concerns differently. Ensuring that these voices are heard, understood, and appropriately supported is essential to maintaining psychological safety and equity within the organisation – Survey respondent

5.6.2 Belonging and fairness

Several participants described a loss of organisational belonging following COVID-19, including:

- fragmentation,
- isolation,
- reduced face-to-face contact,
- and weakening interpersonal relationships.

Participants linked this to:

- poorer collaboration,
- reduced informal support,
- weaker team cohesion,
- and diminished connection to the wider organisation.

Many participants reflected that increasing organisational scale, operational pressure and divisional fragmentation have further reduced opportunities to build relationships across teams and leadership structures. Several participants described feeling disconnected not only from senior leadership, but sometimes from colleagues within their own divisions or specialties.

Participants consistently linked belonging to psychological safety, as discussed in section 5.1, with staff describing greater confidence to contribute, challenge and seek support where relationships are strong and leaders are visible and approachable. Conversely, environments perceived as transactional, hierarchical or fragmented were associated with reduced confidence in speaking up and lower trust in organisational processes.

Several participants also raised concerns regarding fairness and equity of access to influence, leadership and engagement opportunities.

Participants described perceptions that access to; leadership roles, decision-making forums, strategic conversations and informal influence networks Are not experienced equally across the workforce.

Many participants emphasised that fairness is not only about equal opportunity, but about creating equitable access to participation, influence and leadership. Participants repeatedly advocated for more inclusive engagement approaches, broader consultation beyond formal leadership roles and greater recognition of different communication styles, experiences and barriers to participation across the workforce.

Several participants also reflected on how experiences of organisational belonging and fairness are shaped by how people are treated during periods of difficulty, vulnerability or conflict. Some participants described feeling unsupported, dismissed or isolated when raising concerns, experiencing ill health or navigating formal processes.

Participants described inconsistency in how compassion, support and accountability are experienced across teams and staff groups, with some perceiving that organisational responses can be influenced by hierarchy, relationships or professional status.

5.6.2 Belonging and fairness

Several participants reflected that experiences of fairness are strongly shaped not only by formal policies, but by everyday interpersonal behaviours and leadership responses.

Participants particularly valued environments where leaders were:

- approachable,
- compassionate,
- transparent,
- and willing to engage constructively with challenge or distress.

Conversely, some participants described cultures where staff felt:

- unheard,
- blamed,
- managed defensively,
- or treated transactionally during periods of pressure or escalation.

Some participants also described a disconnect between organisational values relating to wellbeing, inclusion and compassion and their lived experience of how staff are treated in practice. This was particularly evident during periods of burnout, sickness absence or formal investigation processes.

Transformation Partners in Health and Care

Section 5.7

Blind spots, strategic gaps and unmet priorities

Participants demonstrated considerable insight into organisational challenges.

A major theme was a perceived disconnect between strategic messaging, transformation programmes and frontline operational reality.

Participants often proposed practical solutions, including:

- *clinicians identifying emerging risks before they become significant problems,*
- *teams openly discussing service pressures and constraints,*
- *willingness to challenge established ways of working,*
- *examples of innovation and service improvement led by frontline staff,*
- *constructive suggestions for strengthening governance, communication and engagement.*

The listening exercise identified a highly engaged workforce with a strong desire to improve services and organisational culture.

5.7.1 Clarity around key issues

Many participants described uncertainty regarding whether there is a shared organisational understanding of the most significant underlying issues affecting culture, workforce experience and patient care.

While participants acknowledged substantial governance activity and operational oversight, several questioned whether the organisation consistently distinguishes between:

- symptoms and root causes,
- isolated incidents and cumulative patterns,
- or operational pressures and deeper relational or cultural problems.

Participants repeatedly asked what senior leaders know and whether cumulative themes are recognised across issues and divisions.

Several participants felt patient experience, workforce wellbeing and psychological safety become secondary.

Participants repeatedly described concerns becoming diluted or fragmented as they move through governance structures and escalation pathways. Several participants in clinical leadership roles described uncertainty regarding what happens once concerns are escalated beyond local level, contributing to perceptions that organisational visibility reduces as concerns move upwards through layers of governance.

A recurring theme was disconnect between operational management priorities and clinical leadership. Many participants described operational, financial and performance pressures as increasingly shaping decision-making, with clinicians feeling required to adapt to organisational targets rather than operational systems supporting safe clinical care.

Several participants questioned whether operational teams and non-clinical decision-makers always have sufficient understanding of frontline clinical realities, cumulative risk or the downstream consequences of operational decisions. Some qualitative discussions also focused on the use of data – whether this was understood and being used appropriately to direct clinical activities.

> We have very little contact with non-clinical leaders and they often seem too busy to listen to issues which require a more long-term solution. I appreciate this is likely owing to pressures on time...but the lack of engagement with clinicians means we feel our hands are tied particularly when trying to improve our service – Survey respondent

Whilst not always the case, **many participants described having challenging relationships with operations colleagues**. This is due to a lack of two-way support and dialogue – with the perception that this focusses on "policing" clinicians to ensure adherence to targets and policies, without any support or listening, meaning issues go unresolved or are missed. Many discussed, in some circumstances never having met operations colleagues and therefore feeling interactions were "faceless".

5.7.1 Clarity around key issues (continued)

Participants also repeatedly described clinical leadership roles as structurally constrained, leading to an organisational lack of clarity around the real issues on the ground.

Clinical leadership was frequently described as:

- operationally overwhelmed,
- managing peers without formal authority,
- and lacking sufficient time, training or organisational support.

Several participants felt these roles carry substantial responsibility without corresponding influence, limiting capacity for strategic leadership, workforce support or longer-term improvement activity. This was frequently contrasted with nursing management structures in terms of clarity of role and resource.

Many called for a review of roles and responsibilities as well as advocating for more decision-making capabilities to be delegated to department and team level – and being trusted to manage their clinical portfolio.

> All these doctors as clinical leads have no training in making decisions – Interviewee 008

Some participants talked about their limited ability to influence strategy and policy, meaning the organisation does not benefit from their professional experience – a missed opportunity.

> It is quite weird situation to be in when I'm influencing national strategy, and people in decision making positions within the Trust could just know what it is going to be if they only talked to me – Interviewee 038

5.7.2 Underestimated risks and priorities

Many participants felt certain risks are consistently underestimated because they develop gradually, become operationally normalised or lack visibility at senior levels.

Examples repeatedly cited included:

- corridor care,
- chronic workforce pressure,
- delayed access to care,
- deteriorating team relationships,
- and sustained reliance on goodwill.

Several participants explicitly stated that the organisation has become: “good at normalising things that should not be normal.” This theme was particularly prominent amongst participants working within acute, surgical and operationally pressured specialties.

Several participants also described scenarios in which they were working over and above their hours through paid overtime or out of goodwill to plug gaps and stopping issues arising. However, it was recognised that this was not sustainable and was effectively masking the situation. There was a general perception that something serious needed to go wrong before issues would become a priority. Participants described this as reactive rather than preventative and inconsistent with principles of organisational learning.

Many participants also described concern that workforce wellbeing, psychological safety and relational culture are underestimated strategically because they are harder to quantify than operational or financial performance measures.

Several questioned whether sufficient organisational attention is given to:

- burnout,
- retention risk,
- leadership capability,
- and cumulative workforce fatigue.

A handful of those we spoke to admitted actively searching for other roles, either with the intention of leaving completely or reducing their time with CUH in favour of other, more rewarding, part-time or private opportunities.

A recurring concern was that operational and financial priorities can, unintentionally, overshadow clinical expertise and early warning intelligence.

Some participants described frustration that clinicians identify risks early but feel constrained in their ability to influence operational decisions or resource allocation. Participants also perceived the organisation as more responsive to external scrutiny, serious incidents, reputational risk or performance deterioration than to repeated lower-level concerns or early warning signs.

Many participants described the organisation as so large and operationally fragmented that relationships with senior leaders are limited or absent meaning divisions function in silos. Specialties spanning multiple Divisions experience competing priorities and diluted accountability. Several participants described Divisional structures themselves as contributing to fragmentation.

5.7.3 Unspoken or difficult-to-raise concerns

Several participants described concerns that were widely recognised within teams but infrequently discussed openly.

These included challenging behaviours, concerns about clinical practice, workforce exhaustion, informal power structures and longstanding operational risks. Participants often characterised these issues as "known but unspoken", suggesting that staff were aware of them through informal conversations and day-to-day experience, but felt constrained from discussing them openly.

Participants linked this to:

- fear of repercussions,
- hierarchy,
- reputational concerns,
- operational pressure,
- and low confidence in organisational responsiveness.

Some participants described environments where staff become cautious about discussing:

- behavioural concerns,
- leadership conduct,
- discrimination,
- operational decision-making,
- or concerns involving influential individuals.

This theme was especially prominent in discussions relating to bullying, interpersonal behaviours, psychological safety and tensions between operational and clinical priorities.

Several participants described concerns becoming softened, sanitised or reframed as they move upwards through governance structures, reducing organisational challenge or discomfort.

Some clinical leaders also described feeling caught between frontline concerns and executive expectations, with limited authority to challenge operational decisions despite retaining responsibility for managing risk locally.

> With the non-clinical leadership, I feel there is a lack of understanding of how much responsibility we (clinicians) are taking, and an unrealistic expectations of how fast we should be working eg triage/A&G, seeing patients, completing admin tasks. I sometimes feel non-clinical leaders see us as privileged, people who earn a lot of money and do very little...what would help is a change in this mentality - Survey respondent

Overall, participants suggested that important organisational intelligence may remain informally contained within teams rather than surfaced openly at an organisational level.

Transformation Partners in Health and Care

Section 5.8

Surfacing best practice

Despite widespread concerns, participants identified many examples of positive practice and conditions associated with stronger culture – present in pockets within the organisation.

Common characteristics included:

- *visible and approachable leadership,*
- *psychologically safe team cultures,*
- *strong multidisciplinary collaboration,*
- *open communication and transparency,*
- *shared ownership of challenges and solutions.*

These examples demonstrate that many of the conditions required for effective medical voice already exist within the organisation and provide a foundation on which future improvement can build.

5.8.1 Behaviours or practices the organisation should protect and build on

Despite concerns raised elsewhere in the report, participants identified many positive behaviours, practices and cultural strengths that they felt should be protected and expanded.

Many participants spoke positively about leaders who are:

- visible,
- approachable,
- responsive,
- transparent,
- and connected to frontline realities.

> I feel our clinical leadership is very good. There is a clear process which is transparent, and there is a lot of understanding of the importance of our concerns, and genuine attempts at trying to resolve issues – Survey respondent

Participants particularly valued leaders who **engage directly with staff, attend team meetings, listen openly to concerns and provide visible follow-through on actions.** These behaviours were consistently associated with higher levels of trust, engagement and psychological safety.

Many participants also described examples of strong multidisciplinary team cultures characterised by:

- supportive peer relationships,
- collaborative working,
- constructive challenge,
- and shared ownership of problems.

Within these environments, concerns were more likely to be discussed early and addressed collectively before escalating into more significant issues. Smaller specialist teams were particularly likely to describe strong cohesion, mutual support and open communication.

Several participants highlighted examples of teams where learning and improvement are embedded within everyday practice. These teams were described as:

- open about mistakes,
- focused on learning rather than blame,
- willing to discuss difficult issues,
- and committed to continuous improvement.

Participants viewed these behaviours as critical to maintaining both patient safety and staff wellbeing.

Interestingly, when looking at survey responses, less than one-third (27%) of respondents feel that positive behaviours supporting safety and collaboration are recognised and reinforced, while most disagree (47%). **This suggests that recognition of good practice is not consistently experienced and may not be sufficiently visible across the organisation. This points to opportunities for organisational learning.**

5.8.1 Behaviours or practices the organisation should protect and build on (continued)

A recurring positive theme was the experience of collaborative working during the COVID-19 response. Participants reflected that during this period:

- decision-making was faster,
- hierarchy reduced,
- clinicians felt empowered,
- and collaboration improved across professional and organisational boundaries.

Many felt this demonstrated the organisation's ability to work flexibly, trust frontline expertise and mobilise around shared goals when required. This signals opportunities to build on existing strengths

> In COVID we were so efficient. No non-essential people involved in decision making. Whole middle layer no longer involved. Was very action oriented. Doctors saw issues, suggested fixes and this got approved – Interviewee 001

5.8.2 Factors that help teams raise concerns and resolve issues effectively

Consultants identified a clear set of conditions that enable concerns to be raised early and resolved effectively. Importantly, participants described these factors as already existing within parts of the organisation, providing a strong foundation on which to build.

The strongest theme was leadership style. Many participants described concerns being raised more readily where leaders are:

- approachable,
- visible,
- responsive,
- and able to understand frontline pressures.

Participants consistently linked effective leadership with creating environments where challenge is welcomed, concerns are acknowledged and staff feel confident that issues will be addressed constructively.

Psychological safety emerged as a critical enabler - discussed in section 5.1. **Participants repeatedly described the importance of supportive team environments where individuals can speak openly without fear of blame, dismissal or negative consequences.** Teams with strong psychological safety were perceived to identify problems earlier, discuss difficult issues more openly and resolve concerns more effectively.

Team cohesion was also identified as a significant protective factor. **Many participants described supportive peer relationships, collaborative teamworking and a shared sense of responsibility for addressing problems.** Several participants noted that staff are often more willing to raise concerns when they know colleagues will support them and when concerns can be discussed collectively rather than in isolation.

Participants also emphasised the importance of visible follow-through. Staff were more likely to engage with organisational processes where concerns were:

- acknowledged,
- tracked,
- communicated transparently,
- and linked to visible action.

Many participants stressed that trust is strengthened when staff understand what has happened following escalation, even where concerns cannot be fully resolved.

Several participants highlighted practical mechanisms that support effective escalation and resolution, including:

- regular team forums,
- opportunities for open discussion,
- early intervention when concerns emerge,
- routine feedback cultures,
- stronger thematic analysis of concerns,
- and learning-focused rather than blame-focused approaches.

> I think our Clinical Lead is really quite good and really quite good at displaying those things that I would be hoping for, like presence, talking – Interviewee 039

5.8.3 Opportunities to strengthen organisational listening

Participants provided a clear and consistent view of how the organisation can strengthen its listening culture in the future. There was notable alignment across specialties, divisions and engagement methods regarding the factors most likely to improve trust, engagement and confidence in speaking up. This suggests that the pathway for improvement is well understood and that the organisation has a strong foundation on which to build.

The strongest theme was the need to strengthen the connection between listening and action. Participants repeatedly emphasised that confidence in organisational listening depends entirely on whether concerns lead to visible action. Many participants described a desire to see clearer ownership of issues, transparent progress updates and evidence that concerns have influenced decisions, priorities or service improvements.

Closely linked to this was a consistent call for stronger feedback loops. Participants wanted greater visibility of what happens after concerns are raised, including acknowledgement of issues, communication regarding progress and transparency when action is not possible. Several participants emphasised that trust can be maintained even when concerns cannot be resolved immediately, provided the rationale is explained openly and honestly.

Many participants also advocated for increased leadership visibility and engagement. Staff consistently valued leaders who are present within clinical environments, understand frontline realities and engage directly with teams. Participants felt that visible leadership helps build trust, improve understanding of operational challenges and strengthen confidence that organisational decisions are informed by frontline experience.

> I would like to see more of the leadership coming to departments without this being a 'big event' (which is what has happened previously). A lot could be learned from watching a department at work and speaking more informally to staff...leaders need to talk to the people involved in this work and facilitate dialogue between clinicians and manager in different divisions around specific projects rather than either ending up having separate conversations with multiple different managers or at the other extreme, keeping this to a generic consultant forum - Survey respondent

Participants identified opportunities to make speaking up more accessible and inclusive. Suggestions included:

- regular forums for discussion and challenge,
- structured engagement opportunities,
- broader consultation beyond formal leadership roles,
- continued discussion of previously raised concerns,
- and anonymous or independent routes for raising concerns.

5.8.3 Opportunities to strengthen organisational listening (continued)

Many participants felt that different staff groups require different mechanisms for participation and that offering multiple routes to contribute would improve both inclusivity and organisational intelligence.

Transparency in decision-making emerged as another important theme. Participants frequently described wanting greater clarity regarding:

- how decisions are made,
- who is involved,
- how competing priorities are balanced,
- and how concerns influence organisational priorities.

Several participants suggested that openly communicating decision-making processes, priorities and constraints would improve understanding and trust, even where difficult decisions are required.

A handful discussed making better use of the expertise of the consultant and SAS doctor workforce.

> [It would be good to] use that expertise that you have as a leader, as a Senior Consultant, to support other colleagues, to guide and advise, because you can do that - Interviewee 037

Participants also highlighted opportunities to strengthen organisational learning and improvement through:

- stronger thematic analysis of concerns (and Datix's),
- improved triangulation of operational data with clinical expertise,
- earlier intervention when concerns emerge,
- better documentation of concerns and actions,
- clearer timelines for delivery,
- testing proposed actions with those who originally raised concerns.
- publication of recurring themes and organisational learning,
- sharing successful approaches between specialties,
- and greater visibility of unresolved risks and mitigation plans.

Participants also highlighted opportunities to build on examples of good practice already present within the organisation. Suggestions included:

- sharing examples of teams demonstrating strong psychological safety and collaborative cultures,
- recognising leaders who model openness, curiosity and responsiveness,
- creating more opportunities for specialties to share learning and service improvement approaches,
- and protecting time for team reflection, learning and multidisciplinary discussion.

Finally, participants consistently emphasised the importance of accountability and visible consistency. Responses repeatedly highlighted the need for concerns to be handled fairly, consistently and transparently, with clear ownership and accountability for delivery. Participants described trust as being built when there is alignment between organisational messages, leadership behaviours and lived experience.

5.8.3 Opportunities to strengthen organisational listening (continued)

Participants' suggestions indicate several practical opportunities for improvement:

- Increase executive and senior clinical leadership visibility through structured frontline engagement.
- Establish regular forums for discussing concerns, reviewing progress and exploring unresolved issues.
- Create clearer feedback loops following Datix reports, investigations and formal escalations.
- Implement routine "You Said, We Did" reporting at Trust, divisional and specialty level.
- Strengthen thematic analysis across Datix reports, complaints, investigations and workforce concerns.
- Publish recurring themes, organisational learning and progress against agreed actions.
- Expand opportunities for anonymous, independent and psychologically safe feedback.
- Broaden consultation beyond formal leadership roles to include a wider range of staff voices.
- Test proposed actions with those who originally raised concerns to ensure responses address the underlying issue.
- Invest in leadership development focused on psychological safety, listening, constructive challenge and compassionate leadership.
- Protect time for team reflection, multidisciplinary learning and service improvement activity.
- Create mechanisms for sharing successful practices between specialties and divisions.

Section 6

Next steps: How CUH will respond

This section sets out how CUH will respond to what has been heard, ensuring that staff voices translate into visible actions and meaningful change. It outlines how findings will be shared, how progress will be tracked transparently, and how opportunities for staff to be heard will continue beyond this listening activity. This section has been developed in collaboration with senior CUH leadership.

How CUH will respond

TPHC will formally hand over this report, including its findings and emerging priority actions to CUH leadership. The report provides an evidence-based understanding of the experiences of consultants and SAS doctors, and highlights the key opportunities to strengthen listening, engaging and working together.

CUH leadership will now consider the findings and emerging priority actions identified in this report, working in partnership with consultants and SAS doctors to translate them into meaningful actions across the organisation.

CUH leadership have committed to:

- **Listening carefully** to the experiences and priorities identified through this report.
- **Working in partnership with consultants and SAS doctors** to priorities and address the emerging challenges and opportunities identified through this work.
- **Being open and transparent**, about progress and continuing the conversation as work develops.
- **Embedding consultant and SAS doctor voice** as an ongoing part of how CUH learns, improves, and makes decisions.

This report is not an end point, but the beginning of an ongoing commitment to strengthen engagement with consultants and SAS doctors. Working together will ensure that the insights from this work are translated to into meaningful action that improves the working environment for consultants and SAS doctors and the care provided to patients.

Section 7

Appendices

Transformation Partners in Health and Care

Appendix 1. Demographics and representation

Demographic representation: gender

The listening activity engaged 115 female consultants/SAS doctors (23% of the female workforce) and 96 male consultants/SAS doctors (14% of the male workforce)*.

Female participation was particularly strong in Divisions A, C and E, where engagement rates were significantly higher, relative to workforce size. Male engagement was lower, proportionately, across all divisions.

It is important to note, however, that the gender question within the survey was optional, and a proportion of respondents either selected “prefer not to say” or did not provide a response. As a result, the gender profile may not fully reflect the true distribution of participants and should be interpreted with some caution when assessing representativeness.

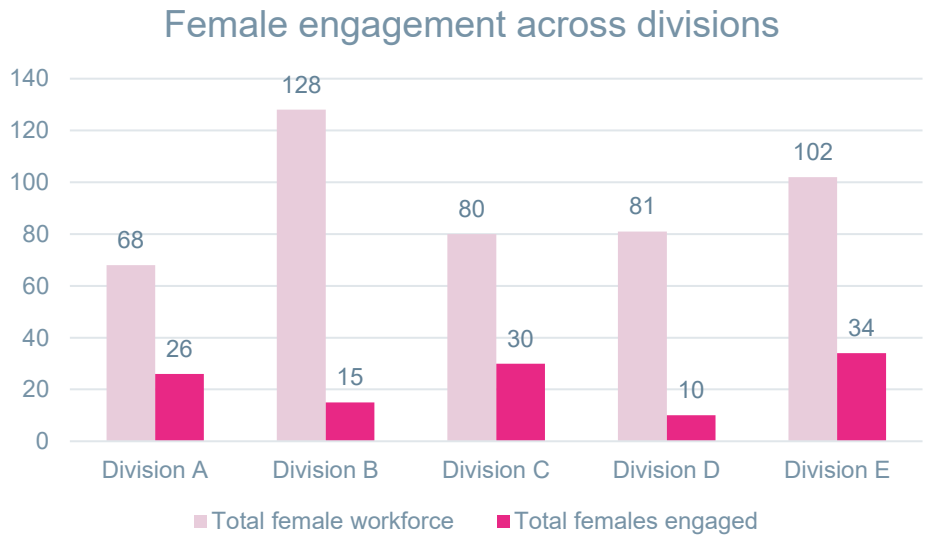

Figure 14: Female engagement across divisions

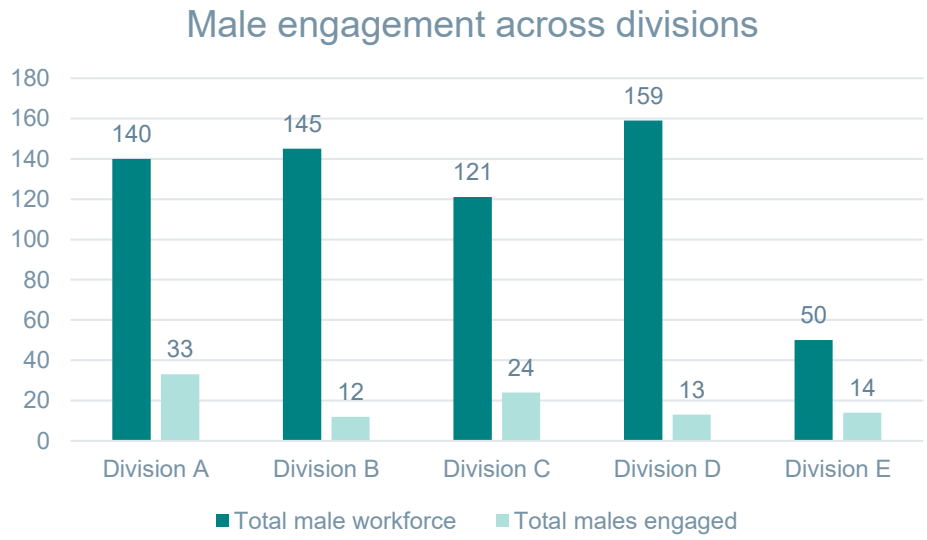

Figure 15: Male engagement across divisions

Demographic questions were non-mandatory in the survey and 1:1 interviews and not gathered during group meetings, therefore representation may not be fully accurate.

Demographic representation: ethnicity

White consultants represent 52% of participants (122 of 233), broadly aligned with the Consultant workforce profile (53%, 644 of 1,221), while consultants from global ethnic majority backgrounds (GBE) represent 15% of participants (36 of 233), compared to 25% of the consultant workforce (305 of 1,221)*.

The participant group was predominantly White across all divisions, reflecting the wider workforce profile.

Asian consultants were the most represented GBE group (with 22 consultants). Engagement from Mixed, Other, and Black backgrounds was limited (14 consultants), with particularly low representation from Black consultants.

16 respondents selected 'prefer not to say' or did not disclose ethnicity, as this was a non-mandatory question, which may affect the overall representativeness of the data.

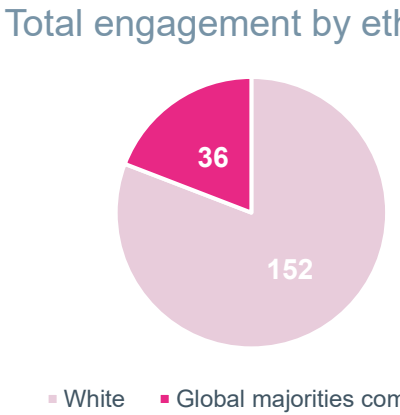

Figure 16: Total engagement by ethnicity

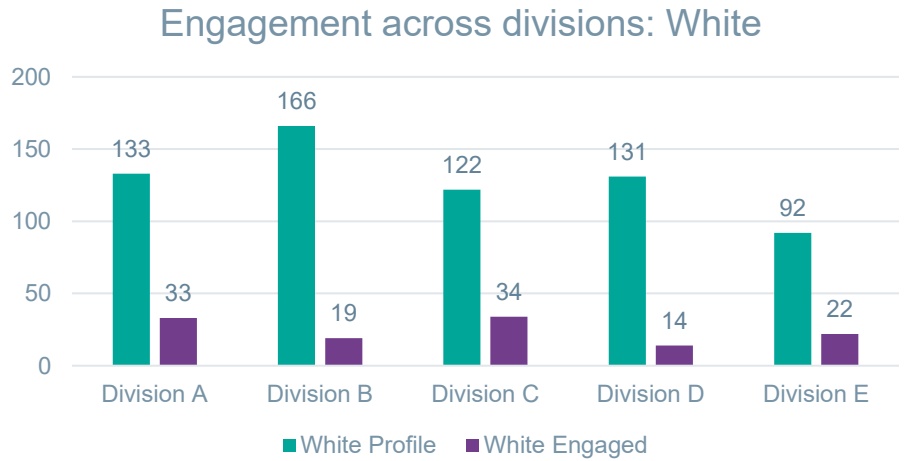

Figure 17: Engagement across divisions: White

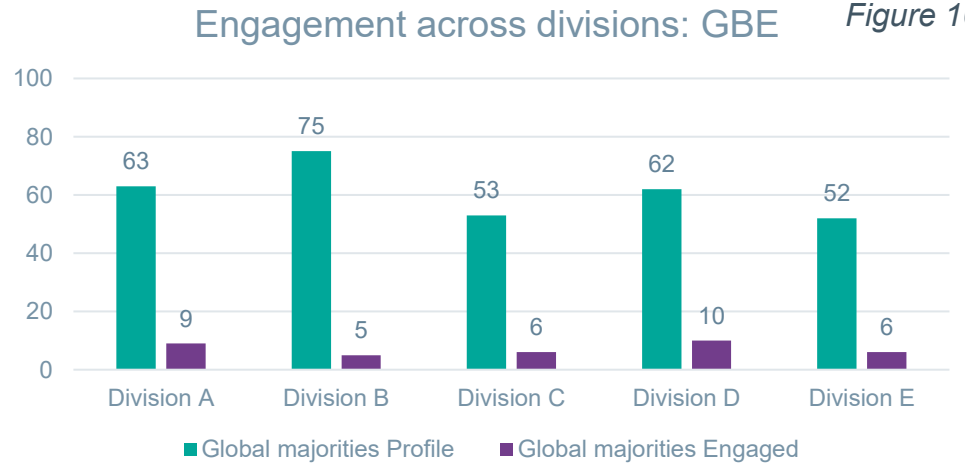

Figure 18: Engagement across divisions: Global majorities

**Demographic questions were non-mandatory in the survey and 1:1 interviews. Ethnicity data was not collected during group meetings, therefore representation may not be fully accurate.*

Demographic representation: time in post and age

Engagement reflects a broad spread of tenure and age, with strongest representation from mid-career consultants and more limited participation at the early career stage*.

- The participant group is predominantly mid-career to long-serving, with the largest representation from consultants in their post for 5-10 years.
- There is strong representation from clinicians with over 10 years' experience, providing deep organisational knowledge and longitudinal perspective.
- Early-career consultants (under 1 year) are less represented, strengthening the findings that junior consultants new in their roles are less likely to speak up.

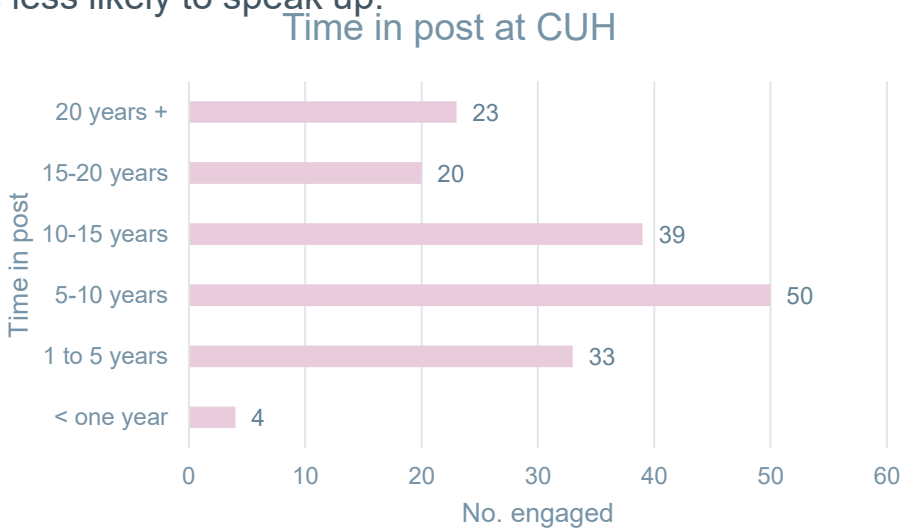

Figure 19: Time in post at CUH

- The age profile is centred around mid-career clinicians, with most participants aged between 40 and 54.
- There is representation from both earlier and later career stages, ensuring a breadth of perspectives across the consultant lifecycle.
- However, the dataset is weighted towards more experienced age groups, meaning insights are primarily shaped by established clinicians.

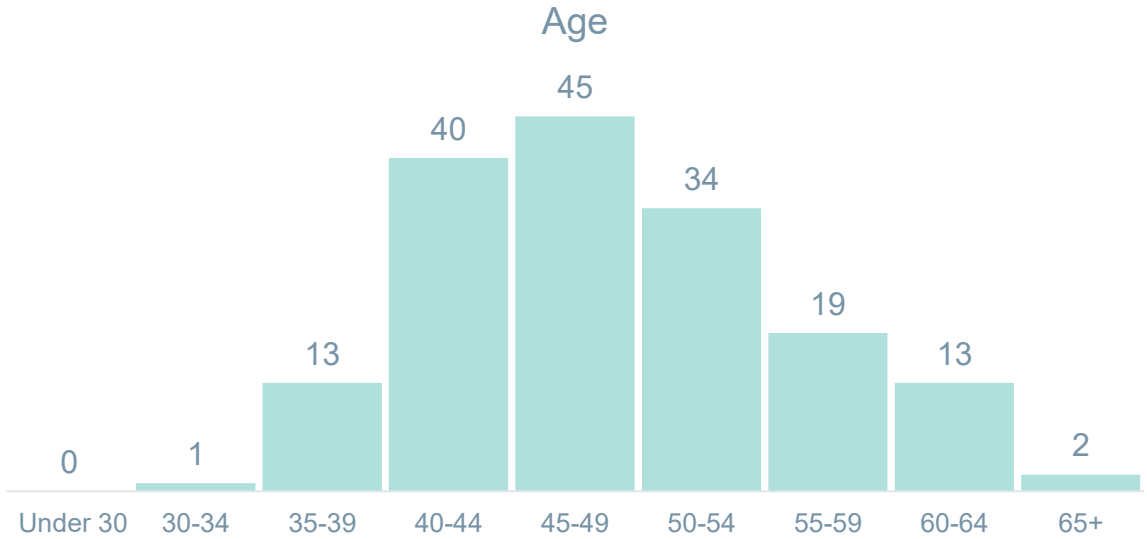

Figure 20: Age

**Demographic questions were non-mandatory in the survey and 1:1 interviews. Time in post and age data was not collected during group meetings, therefore representation may not be fully accurate.*

Engagement numbers in relation to workforce profile - gender

Engagement across all sources* shows variation by division, with Divisions A and C demonstrating the highest overall participation. Female engagement is particularly strong in Division E, while Divisions A and D remain more male-leaning. Division D continues to have the lowest overall engagement across both genders.

Division	Female workforce	% of divisional male and female consultant workforce	**Females engaged**	% engaged out of divisional female consultant workforce	Male workforce	% of divisional male and female consultant workforce	**Males engaged**	% engaged out of divisional male consultant workforce
Division A (t = 213)	68	32%	**26**	**38%**	140	66%	**33**	**24%**
Division B (t = 280)	128	46%	**15**	**12%**	145	52%	**12**	**8%**
Division C (t = 206)	80	39%	**30**	**38%**	121	59%	**24**	**20%**
Division D (t = 256)	81	32%	**10**	**12%**	159	62%	**13**	**8%**
Division E (t = 159)	102	64%	**34**	**33%**	50	31%	**14**	**28%**
Total	**507**		**115 (23%)**		**669**		**96 (14%)**	

Divison A	**Division B**	**Division C**	**Division D**	**Division E**
• Shows strong participation with a slight male dominance, with male voices more prominent overall.	• Demonstrates relatively balanced gender representation, with a slight female lean and more modest overall engagement.	• Has the second highest level of engagement, with a good spread of perspectives and slightly stronger female participation.	• Shows lower overall engagement, with a slight male skew and a clear gap across both genders.	• Strongly female-dominated, with high overall engagement and comparatively lower male participation.

Demographic questions were non-mandatory in the survey and 1:1 interviews. Gender data was not collected during group meetings, therefore representation may not be fully accurate.

Engagement numbers in relation to workforce profile: ethnicity

The listening activity captured engagement across multiple groups, with some divisions demonstrating broader global ethnic majority (GBE) representation alongside strong overall participation.

Division *(CWP = consultant workforce profile)*	White		Asian		Black		Mixed		Other	
	CWP	**Engaged**	CWP	**Engaged**	CWP	**Engaged**	CWP	**Engaged**	CWP	**Engaged**
Division A (t = 213)	133	**33**	47	**5**	1	**0**	7	**3**	8	**1**
Division B (t = 280)	166	**19**	62	**2**	2	**0**	5	**0**	6	**3**
Division C (t = 206)	122	**34**	39	**6**	3	**0**	6	**0**	5	**0**
Division D (t = 256)	131	**14**	46	**6**	4	**1**	5	**2**	7	**1**
Division E (t = 159)	92	**22**	39	**3**	1	**0**	6	**1**	6	**2**
Total:		**122**	233	**22**	11	**1**	29	**6**	32	**7**
Total (White CWP)	**644**		**Total (GBE CWP)**				**305**			
Total engaged in activity (White): 122 out of 233 (52%)			**Total engaged in activity (GBE): 36 out of 233 (15%)**							

Divison A	Division B	Division C	Division D	Division E
• Shows the strongest overall engagement and is predominantly White, but with the broadest spread of minority group participation.	• Has lower overall engagement and is largely White, with limited representation from minority groups.	• Demonstrates high engagement, predominantly from White consultants, alongside a good level of Asian representation.	• Moderate engagement with the most balanced minority group representation relative to size and is the only division with recorded black participation.	• Shows good overall engagement, largely White, with some representation across Asian and other groups.

Demographic questions were non-mandatory in the survey and 1:1 interviews. Ethnicity data was not collected during group meetings, therefore representation may not be fully accurate.

Engagement numbers in relation to workforce profile - age

Engagement peaks in mid-career groups* (41-60), with lower participation from early-career (26-40) and the most senior consultants (65+), indicating strong insight from experienced staff but some underrepresentation at either end of the career spectrum.

1. **Mid-career groups are strongly represented:** highest engagement was seen in ages 46-50 (20%), 41-45 (17%) and also 51-55 (17%), suggests the listening activity was strongest among mid to late career s.
2. **Early career consultants are less well represented:** with lower engagement in ages 26-35 (6%) and 36-40 (9%), this may reflect lower confidence to engage and speaking up.

Division *(CWP= consultant workforce profile)*	26-35 CWP	Engaged	36-40 CWP	Engaged	41-45 CWP	Engaged	46-50 CWP	Engaged	51-55 CWP	Engaged	56-60 CWP	Engaged	61-65 CWP	Engaged	65+ CWP	Engaged
Division A (t = 213)	2	0	26	3	43	8	56	16	37	12	25	6	15	1	5	0
Division B (t = 280)	11	0	43	3	57	10	48	6	52	5	29	1	21	3	13	0
Division C (t = 206)	2	0	26	5	48	10	53	10	31	5	24	5	8	4	9	2
Division D (t = 256)	1	1	32	0	49	6	46	8	40	4	37	4	25	3	10	0
Division E (t = 159)	3	0	22	2	33	6	25	5	39	8	16	3	9	2	6	0
Total	19	1 (6%)	149	13 (9%)	230	40 (17%)	228	45 (20%)	199	34 (17%)	131	19 (15%)	78	13 (17%)	43	2 (5%)

Engagement numbers in relation to workforce profile – time in post

Engagement by tenure* is strongest in mid-career groups across all divisions, with limited representation from early-career consultants and variable participation from the most senior staff.

Division *(CWP= consultant workforce profile)*	< 1 yr CWP	Engaged	1-5 yrs CWP	Engaged	5-10 yrs CWP	Engaged	10-15 yrs CWP	Engaged	15-20 yrs CWP	Engaged	>20 yrs CWP	Engaged
Division A (t = 213)	14	**0**	55	**10**	49	**14**	48	**11**	24	**10**	18	**2**
Division B (t = 280)	26	**1**	79	**7**	65	**9**	51	**6**	23	**0**	29	**5**
Division C (t = 206)	18	**0**	49	**12**	63	**4**	37	**11**	19	**5**	15	**7**
Division D (t = 256)	33	**1**	50	**2**	64	**14**	35	**3**	26	**3**	32	**5**
Division E (t = 159)	17	**2**	45	**2**	44	**9**	23	**8**	12	**2**	11	**4**
Total	108	**4 (4%)**	278	**33 (12%)**	285	**50 (18%)**	194	**39 (20%)**	104	**20 (19%)**	105	**23 (22%)**

Divison A	Division B	Division C	Division D	Division E
• Strongest engagement was within tenure of 5-10 yrs and 10 – 15 yrs. • Lack of engagement within <1 year group means a divisional skew towards more senior consultants.	• Lower engagement generally but a broad spread across different tenures. • Lower engagement in <1 year and 15 – 20 yrs. • Mixed tenure profile in this division.	• Strong engagement in Consultants with a tenure of 1-5 yrs, 10-15 yrs and > 20 yrs. • Good spread across tenure, including highest engagement from early career consultants.	• Strongest engagement in tenure of 5-10 yrs but considerably lower in other tenures. • Engagement is present but less balanced across other tenure bands.	• Highest engagement levels out of all divisions amongst early career consultants with tenure <1 year. • Lowest engagement overall.

Demographic questions were non-mandatory in the survey and 1:1 interviews. Time in post data was not collected during group meetings, therefore representation may not be fully accurate.

Transformation Partners in Health and Care

Appendix 2.

Potential actions arising from feedback around wider organisational issues

Potential actions arising from feedback around wider organisational issues

The listening exercise surfaced several themes that extend beyond medical voice and into areas of governance, organisational design, workforce systems and operational processes. These themes were not the primary focus of the review and therefore do not form part of the emerging priority actions. However, participants identified a range of actions that the organisation should consider as part of wider improvement activity. These have been grouped by Key Line of Enquiry.

KLOE 1: Psychological safety and voice

Participants consistently described psychological safety as a key determinant of whether concerns are raised early, openly and constructively. Feedback highlighted opportunities to strengthen confidence, support and safety when speaking up.

Potential actions identified by participants

- Create forums where previously raised concerns can continue to be discussed and tracked.
- Strengthen support for individuals involved in complaints, investigations or complex speaking-up processes.
- Consider how existing channels, such as Medical Staffing support and Freedom to Speak Up functions are evaluated to gather feedback on effectiveness and appropriateness.
- Review how Freedom to Speak Up functions can support staff who are unable or reluctant to articulate concerns themselves.
- Introduce more routine feedback and reflective practice within teams.

KLOE 2: Representative, credibility and fairness of voice

Participants frequently described variation in who influences decisions, how consultation occurs and whether clinical expertise is sufficiently incorporated into organisational decision-making.

Potential actions identified by participants

- Explore opportunities for greater local autonomy in service development and improvement.
- Review how smaller specialties and less represented groups can contribute more effectively to organisational discussions.
- Consider approaches to increase transparency around prioritisation and resource allocation decisions.

KLOE 3: Risk, early warning and organisational intelligence

Participants described uncertainty regarding how concerns progress through organisational systems, who owns actions and whether issues are resolved following escalation.

Potential actions identified by participants

- Review governance structures to ensure concerns can be escalated efficiently and transparently.
- Test proposed actions and improvements with those who originally raised concerns.
- Review investigation processes to strengthen consistency, neutrality and transparency.
- Explore opportunities for earlier intervention and restorative approaches, where appropriate.
- Strengthen monitoring of investigation recommendations following implementation.

Potential actions arising from feedback around wider organisational issues

KLOE 4: Learning, prioritisation and visible ownership

Participants identified opportunities to strengthen organisational learning by connecting themes, sharing learning more consistently and demonstrating how feedback informs improvement.

Potential actions identified by participants

- Share learning more consistently across specialties and divisions.
- Create opportunities for specialties to share examples of successful service development and improvement.
- Strengthen follow-up arrangements to ensure improvement actions are sustained over time.
- Review how learning from incidents, complaints and investigations is disseminated across the organisation.

KLOE 5: Follow-through, trust and confidence

Participants described differences in how confidently individuals speak up and how influential they feel, highlighting opportunities to strengthen inclusion, representation and equity of voice.

Potential actions identified by participants

- Strengthen support for internationally trained staff and those who may feel less able to challenge hierarchy.
- Celebrate diversity of thought, experience and background more visibly.
- Review opportunities for mentorship and sponsorship programmes.
- Consider how meeting structures and engagement processes can better support different communication styles and preferences.

KLOE 6: Inclusion, belonging and equity of experience

Participants frequently linked their experiences of medical voice to leadership behaviours, accountability, organisational visibility and the quality of relationships between teams and leaders.

Potential actions identified by participants

- Increase visibility of senior leaders within clinical environments.
- Improve communication regarding organisational priorities, constraints and decision-making.
- Explore approaches to strengthen organisational belonging and cross-Divisional relationships.
- Create more opportunities for leaders to engage directly with frontline staff.
- Review how organisational values are reflected in day-to-day behaviours, leadership practice and workforce experience.

Potential actions arising from feedback around wider organisational issues

KLOE 7: Blind spots, strategic gaps and unmet priorities

Participants repeatedly described broader organisational structures, operational pressures and role ambiguity as influencing their ability to shape decisions and resolve concerns.

- ***Potential actions identified by participants***
- Review how clinical expertise informs operational decision-making.
- Clarify roles and responsibilities across clinical leadership, operational management and medical staffing functions.
- Review decision-making processes where operational decisions have significant clinical implications.
- Consider how specialties that span divisions can be better supported.
- Review approaches to workforce planning, succession planning and service change.
- Improve transparency regarding prioritisation decisions where resources are constrained.
- Review whether current divisional structures create unintended barriers to collaboration, accountability or service development.

KLOE 8: Surfacing best practice

Alongside challenges, participants identified examples of effective leadership, psychologically safe cultures and successful local practices that could be strengthened and spread more widely across the organisation.

Potential actions identified by participants

- Identify and share examples of effective local leadership and psychologically safe teams.
- Scale successful approaches to multidisciplinary collaboration and problem-solving.
- Build on existing examples of strong consultant engagement and co-production.
- Create mechanisms for monitoring whether improvement initiatives are having the intended impact.
- Continue to involve consultants and SAS doctors in shaping future organisational improvement activity.
- Share progress against organisational improvement programmes, including actions arising from previous reviews and investigations.