The Royal Society of Medicine

Psychological Safety Conference

Tuesday 9 June 2026, Royal Society of Medicine, London

Psychological safety is a core condition for learning, staff wellbeing, innovation, and patient safety, with repeated emphasis that the real test is not whether staff speak up, but how organisations respond when they do.

OVERVIEW

The Royal Society of Medicine's (RSM) Patient Safety Section brought together clinicians, NHS leaders, whistleblowers and patient voices for a full day of keynote presentations, panel discussions and personal testimony on psychological safety. Held against the backdrop of the NHS 10 Year Health Plan and the NHS Patient Safety Strategy, the conference explored one central question: not whether NHS staff raise concerns, but whether organisations reliably hear, investigate and act on them when they do.

Sessions ranged from the academic foundations of psychological safety through to lived experience of whistleblowing, prison healthcare and organisational redesign, closing with a session on personal commitments delegates could take back into their own workplaces. This debrief expands on the themes covered, drawing out the session-by-session detail behind each theme.

KEY THEMES & DISCUSSION

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What psychological safety is – and isn't

Session 1 – Dr Daljit Hothi, Consultant Paediatric Nephrologist, Great Ormond Street Hospital for Children, and Dr Natalie Wyatt, Paediatric Nephrologist, Evelina London Children's Hospital

The opening session framed psychological safety as the ability to ask questions, admit mistakes, raise concerns and challenge without fear of humiliation, punishment or reputational harm, drawing heavily on Amy Edmondson's and Tim Clark's models. A recurring clarification was that it is not about being nice, avoiding discomfort or lowering standards; rather, it combines high accountability with high safety so teams can stay in a 'learning zone' rather than drift into anxiety, apathy or complacency.

The session traced the concept's research lineage from Schein, Bennis and Kahn through to Edmondson and Clark, and set out evidence that psychological safety improves patient safety, innovation, staff retention, resilience and burnout outcomes.

Edmondson's 'learning zone' model and Clark's four stages of inclusion, learner, contribution and challenger safety were used to show that safety depends on both respect and permission, and that organisations often fail when they expect challenge before first establishing belonging and inclusion.

The discussion that followed brought out practical themes around team identity, belonging, induction, incivility, fragmented teams and the loss of collective culture in the NHS. Participants also stressed that leadership development is inadequate, that teams are too often siloed and transactional, and that practical change requires not just theory but repeated team-level conversations, use of frameworks and a focus on the environment leaders create rather than only on outcomes.

KEY THEMES & DISCUSSION

Leadership, power and the response to speaking up

Session 2 – Dr Chetna Modi, Deputy Director of People & Culture, London, and Chris Streather, Regional Medical Director, NHS England

Leadership behaviour emerged as one of the strongest themes of the day, with repeated claims that psychological safety is shaped decisively by leaders' everyday responses, board conduct and the tone set by senior appointments. Speakers stressed that one senior individual can materially damage trust, morale and openness across an organisation, while boards need both formal metrics and informal intelligence from frontline contact, shadow structures, walk-rounds and direct listening to detect cultural deterioration early.

A major theme in this session was the move from 'encouraging people to speak up' toward improving the organisational response once they do. Speakers argued that systems such as Freedom to Speak Up are valuable but insufficient if leaders still give 'shut up signals,' overestimate how approachable they are, fail to understand positional power, or respond defensively rather than with curiosity.

The session also covered practical leadership interventions, including race inclusion work in the London region – lack of representative leadership, the creation of an 'Inclusion Exec,' buddying arrangements between senior leaders and staff from the global majority, and intentional diversification of leadership pipelines – and a discussion of sexual safety, linking the treatment of sexual misconduct concerns to wider questions of power, vulnerability and listening.

The Q&A expanded into wider issues of board culture and governance. Participants stressed that every major incident analysis tends to show staff had already raised concerns; that the real failure is not absence of voice but the suppression, non-hearing, or dismissal of those voices; and that boards need both formal data and informal intelligence if they are to understand what is actually happening inside organisations.

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Hierarchy, inclusion and multidisciplinary voice

The conference repeatedly returned to the role of hierarchy, professional power and exclusion in silencing staff, especially where non-medical, minority or less institutionally powerful voices struggle to be heard. Discussion of multidisciplinary working highlighted that failures in safety often involve breakdowns in relationships across professions, and that medics and senior leaders in particular have a duty to create conditions in which psychologists, nurses and other professional groups can contribute fully – particularly in high-risk areas such as maternity.

KEY THEMES & DISCUSSION

Whistleblowing, retaliation and the cost of not listening

Session 3 – personal testimony from Mr Peter Duffy MBE, ex-surgeon, whistleblower and author

Several contributions focused on whistleblowing as a severe stress test of psychological safety. Peter Duffy's account centred on whistleblowing following avoidable deaths and safety concerns, and on the severe personal and professional consequences that followed: retaliation after speaking up, financial and career destruction, the unequal and adversarial nature of employment tribunals, the failure of legal processes to examine the original safety concerns, hostile use of regulators, evidence manipulation concerns and profound psychological harm including suicidality.

His wider message was that psychological safety in the NHS remains fragile and that whistleblowers can still lose everything even when later evidence validates their concerns.

The broader discussion suggested these experiences are not isolated, with concern that employment law, tribunal processes and even professional regulators can become mechanisms for suppressing concerns rather than investigating the underlying safety issues.
The Q&A that followed returned to the persecution of people who raise concerns, the weaponisation of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC), the expense and futility of legal suppression, the need for group rather than isolated speaking up and the argument that worker safety is foundational to patient safety.

KEY THEMES & DISCUSSION

Frontline realities: prison healthcare and everyday culture

Session 3 – Dr Liz Walsh, Professional Lead for Justice and Forensics, Royal College of Nursing, and Bethany Carter

Liz Walsh's presentation focused on prison healthcare and the way prison culture shapes psychological safety for staff and patient care: the tension between care and custody, a pervasive culture of suspicion and mistrust, the manipulation risks faced by caring staff, rigid hierarchy, blame and fear and the emotional labour required to remain professional in a setting where vulnerability can itself be dangerous. She argued that prison staff need psychologically safe spaces for supervision and reflection, but that these are hard to create because staff fear judgement, loss of reputation, or exposure in an environment where they depend on non-healthcare colleagues for physical safety.

Bethany Carter contrasted bad and good experiences of speaking up across military and NHS settings, including bullying by senior staff, retaliation after raising concerns and the chilling effect of inaction – contrasted with a later positive experience in which concerns were acknowledged, investigated and acted on. She also described the pandemic experience, where failure to challenge peers on basic practices such as mask wearing had direct consequences for staff transmission, patient safety, admissions and service continuity, reinforcing that psychological safety operates in ordinary daily interactions, not just formal reporting routes.

KEY THEMES & DISCUSSION

Harm to staff as well as patients

Another strong thread across the day was that the absence of psychological safety harms not only patients but staff, teams and families, sometimes immediately and sometimes over many years. Speakers described burnout, distress, guilt, shame, moral injury, damaged careers and prolonged psychological recovery, arguing that worker safety is not secondary to patient safety but foundational to it.

Measurement, accountability and early warning

There was significant interest in whether psychological safety can be measured and whether organisations are held accountable for it, including references to staff survey items, organisational policies and conference polling. The discussion suggested measurement is useful but insufficient on its own, because average scores can hide the experience of the one excluded or fearful individual, and because organisations are often better at measuring harm after the event than sensing deteriorating culture before patient harm occurs.

KEY THEMES & DISCUSSION

Culture change and organisational redesign: what good looks like

Session 4 – Roger Kirby, ex-RSM President; Roger Kline, Research Fellow, Middlesex University; and Beatrice Fraenkel

The afternoon session moved from diagnosis toward 'so what can we do about it?', focusing on culture change during service and organisational redesign. Roger Kirby's contribution focused on the impact of complications and adverse outcomes on clinicians themselves – the emotional burden carried after harm, regret, shame and the importance of helping professionals process error in ways that are humane rather than punitive, illustrated through cases involving clinician distress, suicide, wrong-site surgery, litigation and criminalisation after mistakes.

Roger Kline's contribution focused on what investigations reveal about NHS culture: the absence of a statutory or accepted code of practice for investigations, the fact that investigations themselves often cause harm, the imbalance of power in organisational investigations and the way institutions control the terms, witnesses, publication and consequences of inquiries.

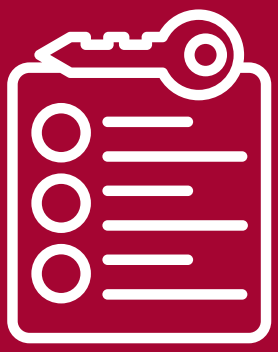
He connected this to wider evidence that many staff do not raise concerns because they expect either futility or retaliation, and highlighted anonymity as a marker of fear and the poor treatment of Black and minority ethnic staff who speak up.

Beatrice Fraenkel brought a governance, design and human factors perspective to the redesign question: that culture change has to be designed into systems, not merely declared, and that redesign should make truthful challenge, safer communication and better decisions easier in practice.

Across the session, the meeting pointed toward practical responses – reflective practice, psychologically safe supervision, compassionate challenge, curiosity instead of blame, better board development, succession planning and more visible, sustained discussion of patient safety in everyday organisational life rather than episodic attention after s candals.

Psychological safety is a whole-system property, not a programme that can be delegated to one team, one department or one enthusiastic individual. Culture must run through the organisation "like a stick of rock"; the gaps between board, services and teams are precisely where safety risk and silence take hold.

Beatrice Fraenkel
Ex Chair of Mersey Care



KEY TAKEAWAYS

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NHS staff already raise concerns – the recurring failure is in how, or whether, organisations hear, investigate and act on them

Leadership behaviour and board culture shape psychological safety more than any policy statement; boards need informal intelligence as well as formal metrics to catch cultural deterioration early

Hierarchy, professional power and exclusion continue to silence non-medical, minority and less powerful voices, particularly within multidisciplinary teams

Whistleblowing remains high-risk: employment law, tribunals and even professional regulators can end up protecting the system rather than examining the original safety concern

Psychological safety protects staff as well as patients – burnout, moral injury and long-term harm follow when it is absent

Practical tools exist – reflective practice, psychologically safe supervision, better board development and stronger whistleblower protection – but need sustained commitment rather than one-off attention after a scandal.

CLOSING STATEMENT

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The conference reinforced that psychological safety is not a policy statement but a daily, relational practice, built through kindness, trust and consistent follow-through when people do speak up. As the NHS navigates the 10 Year Health Plan and continued organisational change, the RSM's Patient Safety Section will continue to bring clinicians, leaders and patients together to keep this conversation active rather than episodic. Delegates left the day with personal commitments to take back into their own teams – a reminder that culture change starts with individual behaviour as well as system redesign.

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This report has been produced by the Patient Safety Section on behalf of the Royal Society of Medicine