

When Things Go Wrong: Increasing Awareness of Closed Cultures and Whistleblowing

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Introduction

Closed organisational cultures within healthcare can allow unsafe practice to persist, particularly when staff and students feel unable or unsupported to raise concerns. High-profile NHS failures, including Mid Staffordshire, Winterbourne View, and the Countess of Chester Hospital, highlight the consequences of poor safety culture and ineffective whistleblowing pathways. In response to organisational learning following a Care Quality Commission report at St Andrew's Healthcare, this poster presents an undergraduate, placement-linked educational intervention designed to improve medical students' recognition of unsafe care, understanding of closed cultures, and confidence in escalation and whistleblowing within psychiatric settings. By evaluating changes in confidence and awareness following a case-based workshop, this work demonstrates the value of early safety culture education in preparing future doctors to recognise risk, speak up, and protect patients.

Discussion

Aim and Objectives

The aim of this workshop was to improve medical students' recognition of unsafe practice, understanding of closed cultures, and improve confidence in whistleblowing within mental health services.

Objectives:

- Increase awareness of historic NHS failures and their relevance to modern psychiatric governance
- Improve confidence in identifying unsafe or abusive care
- Strengthen understanding of escalation and whistleblowing pathways
- Reduce fear and uncertainty around raising concerns as students

97 responses submitted

Name one possible barrier that might stop a healthcare worker from raising concerns.



Affiliation

This workshop was developed and delivered by St Andrew's Healthcare, Northampton, and undergraduate medical leads for the University of Buckingham and Cambridge. The educational intervention was integrated into psychiatry placements at St Andrew's Healthcare, with medical students from both universities participating as part of their undergraduate clinical training. The project was supported by senior clinical and educational staff within the organisation, aligning with local governance priorities and national standards for patient safety and professional responsibility in psychiatry.

Methods

- Design: Placement-linked, interactive educational workshop
- Duration: 60–90 minutes
- Participants: 3rd-year medical students (University of Buckingham) 4th-year medical students (University of Cambridge)
- Sample size: Pre-session feedback: n = 90 Post-session feedback: n = 85

Intervention:

- Small-group, case-based learning
- Students researched Mid Staffordshire, Winterbourne View, and the Countess of Chester Hospital
- What went wrong
- Cultural and organisational failures
- Impact on modern safeguarding, governance, and psychiatric practice
- Facilitated discussion on: Closed culture warning signs Barriers to speaking up Local and national whistleblowing pathways

Evaluation:

- Matched pre- and post-session Microsoft Forms
- 1–5 Likert confidence ratings
- Free-text reflective responses
- Descriptive analysis with percentage change reporting

Qualitative Insights

Students reported:

- Greater clarity around professional responsibility to speak up
- Reduced fear of escalation and repercussions
- Improved recognition of early warning signs of closed cultures

Selected student reflections:

"I feel much clearer about when and how to raise concerns, even as a student."
"The real cases made it feel relevant rather than theoretical — this could happen anywhere."

Strengths

- Grounded in real NHS and organisational learning
- Interactive, learner-centred design
- High relevance to psychiatric practice and GMC expectations
- Scalable and transferable across placements

Limitations

- Single-centre intervention
- Descriptive analysis only
- Short-term outcomes measured
- Informal qualitative analysis

Key Educational Outcomes

- Improved safety literacy in undergraduate psychiatry placements
- Normalisation of whistleblowing as a professional duty, not a personal risk
- Increased confidence engaging with governance and safeguarding structures
- Enhanced preparedness for real-world ethical and organisational challenges

Results

Quantitative Outcomes

- Confidence recognising unsafe or abusive care: increased by 17.6%
- Confidence in how to raise concerns / whistleblowing: increased by 28.9%

Pre-session



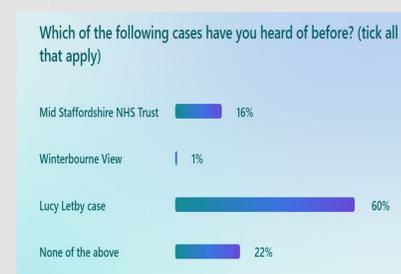
Post session



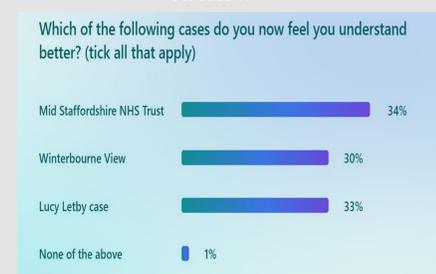
Awareness of major NHS failures:

- Pre-session: Winterbourne View awareness: 1%
- Post-session: Improved awareness across all three landmark cases

Pre-session



Post session



Conclusions

This placement-linked, case-based workshop significantly improved medical students' awareness of closed organisational cultures and confidence in recognising and escalating concerns within psychiatric settings. By grounding learning in real NHS failures and local organisational reflection, the intervention enhanced safety literacy, reduced fear around whistleblowing, and reinforced speaking up as a professional duty rather than a personal risk. Embedding structured safety culture education into undergraduate psychiatry placements may strengthen future clinical practice, promote transparency, and contribute to safer mental health services.

In your own words, what does "whistleblowing" mean in the NHS context?

