Journal of Advanced Nursing

WILEY

SPECIAL ISSUE Patient Safety in Health Care

JAN Leading Global Nursing Research

REVIEW OPEN ACCESS

Exploring Students' Perceptions and Experiences of Raising Concerns During Pre-Registration Training in England: A Systematic Review

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Received: 20 May 2024 | **Revised:** 5 December 2024 | **Accepted:** 10 January 2025

Funding: The authors received no specific funding for this work.

Keywords: education | patient safety | pre-registration | raising concerns | safety culture | speaking up | students | systematic review

ABSTRACT

Aim: To explore the perceptions and experiences of students raising concerns during pre-registration health and/or social care training in England.

Design: Systematic review.

Data Sources: MEDLINE, CINAHL, ERIC, PsycINFO and Education Research Complete were systematically searched for studies published between September 2015 and August 2024. Grey literature searches were conducted using Google Scholar and ETHOS British Library. Reference lists from included studies were hand searched.

Methods: Joanna Briggs Institute methodological guidance for the conduct of systematic review informed conduct and the convergent integrated approach. Mixed methods appraisal tool was used for quality appraisal.

Findings: Eleven studies were included. Synthesis of findings generated three themes: (1) conflicting needs of self and others, (2) navigating the professional workspace and, (3) 'choice to voice'.

Conclusion: Speaking up and raising concerns as a pre-registration student is a complex, multi-faceted and non-linear social phenomenon. Experiences and perceptions are impacted by the novice student position alongside individual, interpersonal and organisational factors. Open cultures within teams and organisations, leadership, support and feedback may enable students overcome barriers to raising concerns.

Impact: Raising concerns may reduce avoidable harm. Pre-registration students offer a 'fresh pair of eyes'; however, they face barriers related to their student position. Synthesis of speaking-up experiences and perceptions of students in English settings can inform the design of learning environments which equip pre-registration students with the knowledge and skills required to cultivate safety behaviours. These skills contribute positively to safety culture and support learning and improvement in complex systems such as health and social care.

Reporting Method: The review followed PRISMA reporting guidelines.

Patient or Public Contribution: The conceptualisation of this project was informed by engagement events with higher education staff, students and Freedom to Speak Up Guardians.

1 | Introduction

Reports of systemic failings at Mid-Staffordshire NHS Foundation Trust in England (Francis 2013) drew significant attention to improving the systems that support health and social care staff to speak up and raise concerns. The subsequent publication of national guidance for workers and employers in health and social care settings (Speak Up 2014) highlighted a national commitment to encouraging workers to raise concerns openly as part of normal everyday practice. The 2016 implementation of Freedom to Speak Up Guardians into National Health Service hospital Trusts in England further aimed to support individuals and organisations to raise, respond to and learn from concerns raised. More recently, the Freedom to Speak Up policy for the NHS (NHS England 2022) states that speaking up can be about 'anything that gets in the way of patient care or affects your working life'. However, recent inquiries continue to highlight missed opportunities to support speak up cultures or learn effectively from concerns raised, suggesting that communication from patients, families and staff is a critical factor in recognising and responding to safety concerns in health and social care (Kirkup 2022; Ockenden 2022; Child Safeguarding Practice Review Panel 2022; Leary et al. 2021).

Recognising and speaking up about concerns is instrumental in efforts to reduce avoidable harm (Wolf and Hughes 2008; Hémon et al. 2020) and supports learning and improvement in complex systems such as health and social care. Speaking up is an important safety behaviour (Nacioglu 2016; Hoffmann et al. 2022) and is integral to professional accountability (Reid and Bromiley 2012). However, despite recognition that speaking up may mitigate harm and optimise outcomes, speak up practices among qualified health and social care staff are not consistent (Morrow, Gustavson, and Jones 2016; Umoren et al. 2022). The motivations and decision to speak up and raise concerns in health and social care are complex. Contextual factors, such as organisational culture and perceived efficacy of speaking up, in addition to individual factors such as motives, values, relationships, competence and self-efficacy have been found to be associated with the decision to speak up or remain silent (Lainidi et al. 2023; Nacioglu 2016; Manthorpe et al. 2016; Schwappach and Gehring 2014).

Professional bodies that regulate health and social care professions, including social work, outline the responsibility of registrants to raise concerns immediately if patient or public safety is at risk (Nursing and Midwifery Council (NMC) 2018; Health and Care Professions Council 2016b; Social Work England 2019). During their training, health and social care students are also expected to raise concerns as appropriate, and education providers must ensure that adequate systems, processes and support are in place to support students in raising concerns (Nursing and Midwifery Council 2023; Health and Care Professions Council 2016a; Social Work England 2023). Key legislation, including the Public Interest Disclosure Act 1988 and the Protected Disclosure Act 2012, supports individuals in raising concerns and protects them from any detrimental treatment which may result. Amendments made in 2015 to the 1996 Employment Rights Act led to Nursing and Midwifery students, and other students provided with work experience pursuant to a training course, being officially recognised 'workers' and thus offered the same protections. However, this legislation is complex and specific criteria must be met in relation to the individual speaking up, the issue raised and to whom it is raised (NHS 2022).

The Francis Inquiry and Report (Francis 2013) identified that student nurses were a 'fresh pair of eyes' who were well placed to offer a perspective or challenge unwanted practice. However, the report also identified how student nurses suffered detriment, with students failing practice placements and/or experiencing bullying due to raising concerns. It has since been found that students on pre-registration health and/or social care training courses do raise concerns about quality and safety; however, this carries an emotional burden and may lead to sanctions (Milligan et al. 2016). The need to explore the perceptions and experiences of students and to further understand barriers and enablers to raising concerns has been identified in a previous systematic review (Milligan et al. 2016).

For registered staff and workers, the steep or rigid hierarchical gradients within health and care environments have previously been identified as a barrier to speaking up (Umoren et al. 2022; Brennan and Davidson 2019; Beament and Mercer 2016; Schwappach and Niederhauser 2019). A 2023 systematic review found that for registered staff, those lower in the 'hierarchy' need more supportive policies to be able to speak up equally to staff higher in the hierarchy of the team (Lainidi et al. 2023). This may indicate that the relatively low hierarchical position of students could impact their speaking up perceptions and experiences, thus requiring targeted interventions, mechanisms and support.

Before implementing changes in a complex system, it is important to understand the existing system—including patterns of relationships, power and fear—in addition to structures and processes (Plsek 2003), as different speaking-up solutions are needed for different contexts (Lainidi et al. 2023). This review will therefore synthesise data from studies conducted in England, with the aim to contribute to knowledge in this specific geographical context and support responsive interventions. Additionally, aligning with the aim of integrated care systems to 'join up' health and care services, this systematic review therefore seeks to further understand health and social care students' experiences and perceptions of speaking up during pre-registration in England. It is hoped that deeper understanding of speaking-up experiences and perceptions of students in English settings will provide evidence to support those involved in health and social care education in England to design responsive learning environments where speaking up is embedded as 'business as usual' in the training of health and social care professionals.

2 | The Review

2.1 | Aim and Objectives

The overall aim of this systematic review was to explore the perceptions, experiences, enablers, and barriers to students raising concerns during pre-registration health and/or social care training in England. The review had two objectives:

1. To explore what is known about the experiences and/or perceptions of students who raise a concern during their pre-registration health and/or social care training.

2. To develop an understanding of the barriers and enablers, as experienced and/or perceived by students, to raising concerns during pre-registration health and/or social care training.

2.2 | Design

A systematic review protocol was generated and registered on PROSPERO International prospective register of systematic reviews: ID CRD42023429024. The review was conducted using Covidence systematic review software; Covidence being a web-based collaboration software platform that streamlines the production of systematic and other literature reviews. PRISMA guidelines for reporting systematic reviews were followed. PICo (Population, Phenomena of Interest, Context) formats support exploration of experiences or meaningfulness of a particular phenomenon (Munn et al. 2018); therefore a PICo (Table 1) was generated to focus the research question, guide the design of the inclusion criteria and inform the search strategy. Data synthesis was informed by a convergent integrated approach (Stern et al. 2020). Accordingly, quantitative data was 'qualitised' prior to integration (Stern et al. 2020), therefore meta-analysis was not performed. Findings are presented as a narrative synthesis.

2.3 | Search Methods

Systematic searches were conducted in the electronic databases: MEDLINE, CINAHL, ERIC, PsycINFO and Education Research Complete. Preliminary searches of the literature informed the key words used in the search strategy (Table 2). Keyword searching with appropriate synonyms and truncation were used in accordance with the rules and requirements of each database. This systematic review wished to extend a previous systematic review commissioned by the Council of Deans of Health (Milligan et al. 2016) that included studies published up to September 2015. Therefore limiters were used to search for studies published between September 2015 and August 2024 in the English language. Grey literature searches were conducted using Google Scholar and ETHOS British Library, using the same keywords. ETHOS British Library was unavailable following a cyber incident in 2023; therefore this database was searched for papers added between September 2015 and February 2023. Reference lists from included studies were hand searched.

2.4 | Inclusion/Exclusion Criteria

Primary qualitative, quantitative and mixed/multi methods research papers undertaken in England that were concerned with perceptions and/or experiences of students who raise a concern during pre-registration health and/or social care training or identified barriers and enablers to raising concerns during pre-registration health and/or social care training were included in the review. The geographical limitation was imposed as both health care and higher education policy, procedures and practices differ across the devolved nations and internationally, and it was deemed important that the specific

TABLE 1 | PICo.

Population: Students during their pre-registration health and/or social care training in England.
Phenomena of interest: Participants will include students during their pre-registration health and/or social care training. Participants must have had experience with, or address students' perceptions of, raising concerns during their pre-registration training. Participants must report/identify barriers or enablers to raising concerns during their pre-registration training.
Context: *Speaking Up/Raising concerns*: It is acknowledged that the term 'Speaking up' can be used interchangeably with 'raising concerns' and/or 'Whistleblowing', although the latter term is most often associated with formal processes or matters escalated outside of an organisation and can have negative connotations (NGO 2024). The National Guardian Office places no limitations on the subject, type or nature of issues that individuals can 'speak up' about, stating that people can speak up about 'anything which gets in the way of patient care and worker well-being' (NGO 2024), therefore this approach is used in this review. The act of speaking up may take many forms, including informal discussions, improvement suggestions or formal raising concerns' processes (ibid). *Setting*: For the purpose of this review, the 'setting' may be defined as either the university or clinical/practice placement, in accordance with the pre-registration programme of training.

TABLE 2 | Search strategy.

Search line	Field	Keywords
Line 1 (Search 1)	Title/abstract	(whistleblow* OR quality OR "raising concerns" OR "patient safety" OR safeguarding OR "poor care" OR reporting OR "speaking up" OR "spoke up" OR "speak up")
Line 2 (Search 2)	Title/abstract	Student*
Line 3 (Search 3)	Title/abstract	(nurs* OR midwi* OR perioperative OR physiotherap* OR podiatr* OR paramedic* OR "allied health" OR "social work" OR "social worker" OR occupational OR radiographer OR NHS)
Line 4 (Search 4)	Title/abstract	S1 AND S2 AND S3

context and environment of the phenomenon of interest were considered in order to make context-specific recommendations. Data from studies conducted outside of England were excluded from the review.

2.5 | Search Outcome

References were imported into Covidence. Duplicates were first removed first electronically and the remaining removed manually. All screening was performed independently by two reviewers (C.P. and H.A.S.). Titles/abstracts were initially screened, and ineligible articles excluded. Where inclusion could not be determined via title/abstract screening, papers were moved to full-text review to determine eligibility for inclusion. Studies were required to meet the full inclusion criteria. Discrepancies were resolved through discussion and while a third reviewer (E.C.) was available to assist in resolving disagreements, this was not required.

2.6 | Quality Appraisal

The Mixed Methods Appraisal Tool (MMAT) (Hong et al. 2018) is specifically designed for use in systematic mixed study reviews has previously been used in numerous health science reviews (Lewis et al. 2020). The MMAT was applied independently by three researchers (C.P., H.A.S. and V.C.) to critically appraise included studies. Consensus was reached through discussion. MMAT guidelines discourage the calculation of an overall quality appraisal score (Hong et al. 2018). Findings were not used to inform inclusion or exclusion of studies, but instead to inform interpretation and methodological quality. Table 3 shows a summary of results of the MMAT quality assessment.

2.7 | Data Abstraction

Three reviewers (C.P., H.A.S. and V.C.) independently extracted data from the included studies using a framework approach and a researcher-generated, piloted data extraction form. Author, year, study design, methods, population, sample size and results (quantitative data) were extracted. A framework of key concepts (experiences, perceptions, barriers and enablers) was utilised to address the question of 'what counts as data' in qualitative studies (Thomas and Harden 2008). Findings from the three independent data extractions were checked by a fourth reviewer (EC). Where studies involved multiple participant groups or geographical locations, data were extracted from the English setting. Additional data not meeting inclusion criteria were discarded.

2.8 | Synthesis

The Joanna Briggs Institute methodological guidance for the conduct of mixed methods systematic reviews (Stern et al. 2020) was selected to inform the approach to data synthesis. This guidance offers a transparent and structured approach to data synthesis when review questions can be answered by both qualitative and quantitative data. Its convergent integrated approach through a process of 'qualitising' quantitative data was felt to be congruent with the underpinning interpretivist research paradigm.

Extracted data was initially coded by three researchers (C.P., H.A.S. and V.C.) in accordance with the pre-defined framework. An interpretivist philosophy underpinned data synthesis, recognising the presence of multiple realities in the minds of individuals. During analysis, multiple perspectives were utilised to enable reflexivity and enhance trustworthiness of findings (Patton 2002; Probst 2015). Extracted quantitative data were then 'qualitised'—a process which transforms quantitative data into statements, narrative or themes. Qualitised data were then assembled into categories with other qualitative data based on similarity of meaning. To ensure a reflexive approach to synthesis, two researchers (C.P. and E.C.) separately analysed data inductively, generating initial categories. These categories were iteratively revisited. Reflexive discussion, comparison and revision of themes generated of higher level analytical themes and subthemes which are presented as a narrative. This synthesis process is documented in Supporting Information 1: Convergent integrated synthesis table.

3 | Results/Findings

3.1 | Search Outcome

Systematic searches retrieved 9648 references. After removal of duplicates, a total of 7520 studies were screened. The full text of 106 studies were screened against the inclusion criteria. One PhD study (Wilson 2023) identified for full-text review could not be retrieved despite extensive efforts. Ninety five studies were excluded due to not meeting inclusion criteria (see Figure 1).

A total of 13 studies initially met the inclusion criteria for this review; however, for two of these studies (Tee, Üzar Özçetin, and Russell-Westhead 2016; Capper, Muurlink, and Williamson 2021), it was not possible to extract the data from the English setting as the data were not stratified per nation/country. Eleven studies (14 references) were included in the review. Multiple reports of a single studies were merged at the point of data extraction.

3.2 | Study Characteristics

Of the 11 studies identified for inclusion in this review, the majority ($n = 7$) employed qualitative methodologies including grounded theory (Blowers 2016, 2018), descriptive transcendental phenomenology (Cooper 2020), hermeneutic phenomenology (Craig and Machin 2020; Fisher 2017; Fisher and Kiernan 2019) and thematic analysis (Walker et al. 2024; Okiki, Giusmin, and Hunter 2023; Rees et al. 2024). The remaining studies ($n = 4$) used mixed methods methodologies (Field-Richards et al. 2024; Groothuizen 2020; Hallett, Wagstaff, and Barlow 2021; Jack et al. 2020, 2021). No quantitative studies were identified. Studies were published between 2016 and 2024. Participants represented nursing, midwifery and speech and language courses. Table 4 summarises the characteristics of included studies.

TABLE 3 | Summary of MMAT quality appraisal.

		Blowers (2016, 2018)	Cooper (2020)	Craig and Machin (2020)	Fisher (2017) and Fisher and Kiernan (2019)	Groothuizen (2020)	Hallett, Wagstaff, and Barlow (2021)	Jack et al. (2020)	Field-Richards (2024)	Okiki, Giusmin, and Hunter (2023)	Rees et al. (2024)	Walker et al. (2024)
1	Are there clear research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Do the collected data allow to address the research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	Is the qualitative approach appropriate to answer the research question?	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	Y	Y
4	Are the qualitative data collection methods adequate to address the research question?	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	Y	Y
5	Are the findings adequately derived from the data?	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	Y	Y
6	Is the interpretation of results sufficiently substantiated by data?	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	Y	Y
7	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Y	Y	Y	Y	N/A	N/A	N/A	N/A	Y	Y	Y
23	Is there an adequate rationale for using a mixed methods design to address the research question?	N/A	N/A	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
24	Are the different components of the study effectively integrated to answer the research question?	N/A	N/A	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A

(Continues)

TABLE 3 | (Continued)

		Blowers (2016, 2018)	Cooper (2020)	Craig and Machin (2020)	Fisher (2017) and Fisher and Kiernan (2019)	Groothuizen (2020)	Hallett, Wagstaff, and Barlow (2021)	Jack et al. (2020)	Field-Richards (2024)	Okiki, Giusmin, and Hunter (2023)	Rees et al. (2024)	Walker et al. (2024)
25	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	N/A	N/A	N/A	N/A	Y	Y	Y	Y	N/A	N/A	N/A
26	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	N/A	N/A	N/A	N/A	Y	N	Y	Unable to identify	N/A	N/A	N/A
27	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	N/A	N/A	N/A	N/A	Y	Unable to identify	Y	Y	N/A	N/A	N/A

Note: Rows 8–22 are omitted as not applicable. The rows presented are applicable to the study designs included in review.

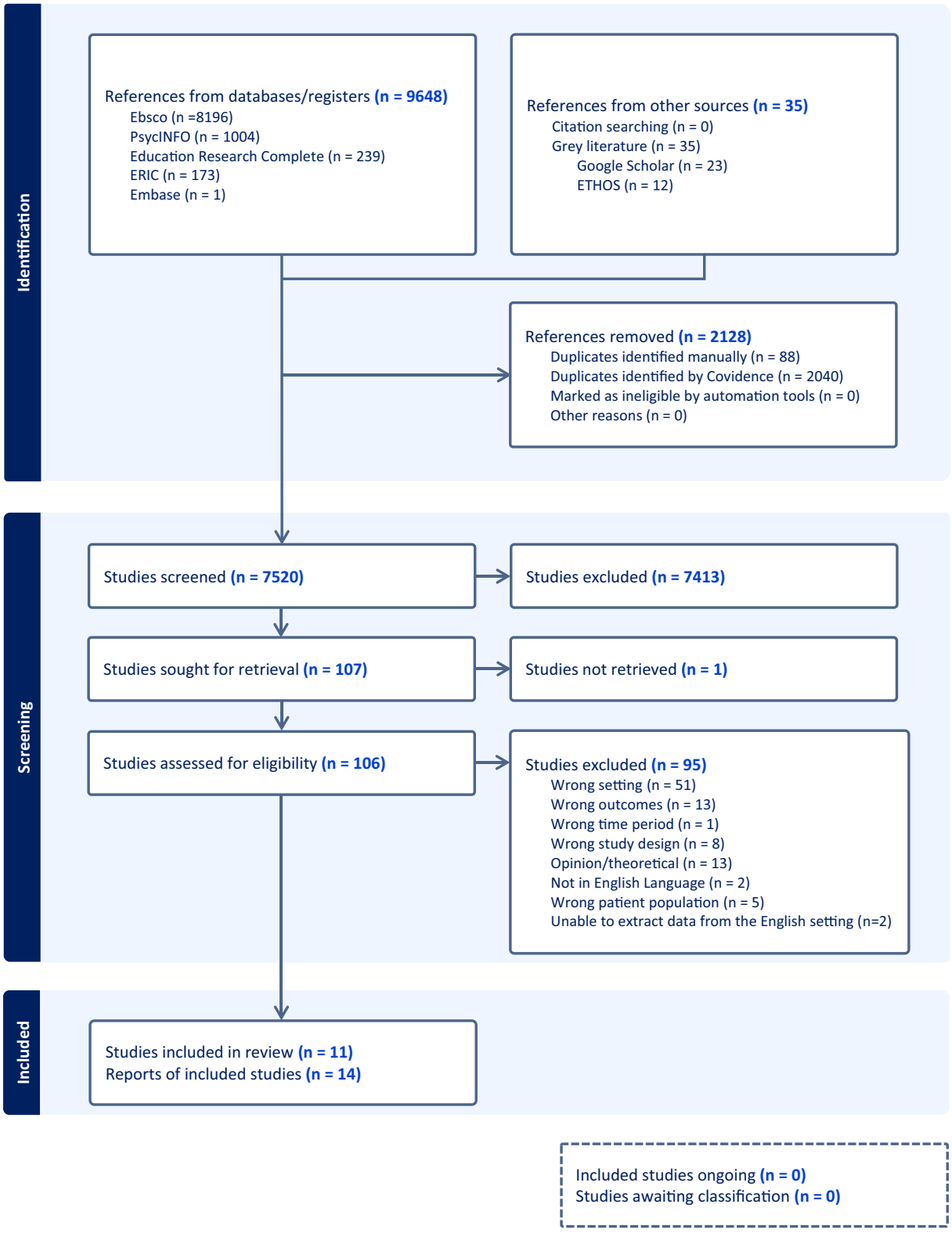

FIGURE 1 | PRISMA flow diagram.

3.3 | Themes

Three core themes with 14 associated sub-themes were generated via synthesis of integrated data. While these are discussed in turn, they represent the overlapping, non-linear and dynamic factors that characterise the complex social phenomenon of speaking up and raising concerns (see Figure 2).

3.3.1 | Conflicting Needs of Self and Others

3.3.1.1 | **'Not That Easy'.** Students perceived and experienced speaking up as a complicated or difficult situation (Blowers 2016, 2018; Cooper 2020), where the ability to speak up is 'contingent on circumstances' (Blowers 2016, 2018). Phrases including 'ruffl[ing] feathers', 'making waves' and 'opening a can

TABLE 4 | Characteristics of included studies.

Author, year	Design and methodology/ methods	Setting	Participants	Summary
Blowers (2016, 2018)	Qualitative—grounded theory Face-to-Face interviews (one-to-one) and focus groups	One university: East England	Pre-registration nursing (all fields) Interviews ($n=4$ initial and follow-up) Focus groups ($n=12$)	This grounded theory research explored students', mentors' and lecturers' experiences of professional integrity in pre-registration nurse education
Cooper (2020)	Qualitative—descriptive transcendental phenomenology Interviews	One university: NW England	Second and third year undergraduate nurses (adult and learning disability fields) ($n=10$) Participants were all female and ethnic diversity was limited, however reflected a typical cross-section of ages consistent with the University's population of nursing students	The study explored the experience of nursing students who raise a care concern in practice, their motivations for raising a care concern and how perceived barriers to raising a care concern are overcome
Craig and Machin (2020)	Longitudinal—Hermeneutic phenomenology Interviews	One university: Northern England	Adult student nurses in all years of study (follow-up 1 year of registered practice) ($n=15$)	This study aimed to understand service improvement experiences of undergraduate adult nursing students in their final university year and up to 12 months into their graduate practice
Field-Richards et al. (2024)	Concurrent triangulation mixed methods. Telephone interviews; questionnaires and focus groups	Three universities: England	Pre-registration nursing students. Participant numbers at time were telephone interviews $n=10$; questionnaires $n=220$ and focus groups $n=8$	Examined if paid prior care experience impacted on the values and behaviours of pre-registration nursing students (including reporting concerns)
Fisher (2017) and Fisher and Kiernan (2019)	Phenomenological (hermeneutic) Interviews and focus groups	One university: Northern England	Students on BSc adult nursing course—all years ($n=12$)	Aimed to understand student nurses' perception of what they believe is a patient safety incident in their practice placements and understand the factors that influence willingness or reluctance to raise concerns
Groothuizen (2020)	Sequential mixed methods design with embedded triangulation A researcher-developed instrument (Situation Judgement Test [SJT]) and 'discussion sessions'	One university: SE England	First, second- and third-year students of adult nursing students ($n=37$)	Aimed to explore potential differences in values between first, second- and third-year students of adult nursing, and to explore whether students' values change upon exposure to clinical practice environments

(Continues)

TABLE 4 | (Continued)

Author, year	Design and methodology/ methods	Setting	Participants	Summary
Hallett, Wagstaff, and Barlow (2021)	Concurrent mixed methods—Cross sectional MM survey and focus groups	Two large universities in one English major city	Pre-registration nursing students across all years and fields who had completed at least one clinical placement (Survey $n = 129$ [7.5% response rate] focus groups $n = 36$)	Researchers aimed to identify the prevalence of, and nursing student experiences of aggression in clinical placements, alongside the rates and experiences of reporting aggression
Jack et al. (2020, 2021)	Concurrent mixed methods—Cross sectional MM survey (not validated tool)	Three universities: Scotland; Australia; England Data extracted from English setting (one HEI in northern England)	(English site) Adult and mental health nursing branches—all years	Aimed to explore the care delivery practices experienced by nursing students while undertaking placements, and to describe incidences of poor care. the study also reports on student perceptions of reporting incidents across the quant and qual elements
Okiki, Giusmin, and Hunter (2023)	Qualitative methods utilising feminist, inductive, interpretivist paradigm. Reflexive thematic analysis. Interviews and focus groups	Three universities: SE England	Thirteen student midwives	To explore the experiences (university and placement) of Black, Asian and minority ethnic midwifery students
Rees et al. (2024)	Qualitative methods—reflexive thematic analysis. Focus groups	One university in an English major city	Nine students on a two-year master's pre-registration SLT programme and who self-identified as being from an ethnic minority background	To explore, and identify ways to improve, the experiences of ethnic minority students
Walker et al. (2024)	Qualitative methods—thematic analysis with an inductive approach Semi-structured interviews	One NHS Trust in an English major city	Out of 21 eligible participants—10 were from an ethnic minority group	To understand how student nurse experiences on differ between ethnic minority and White British nursing students on placement

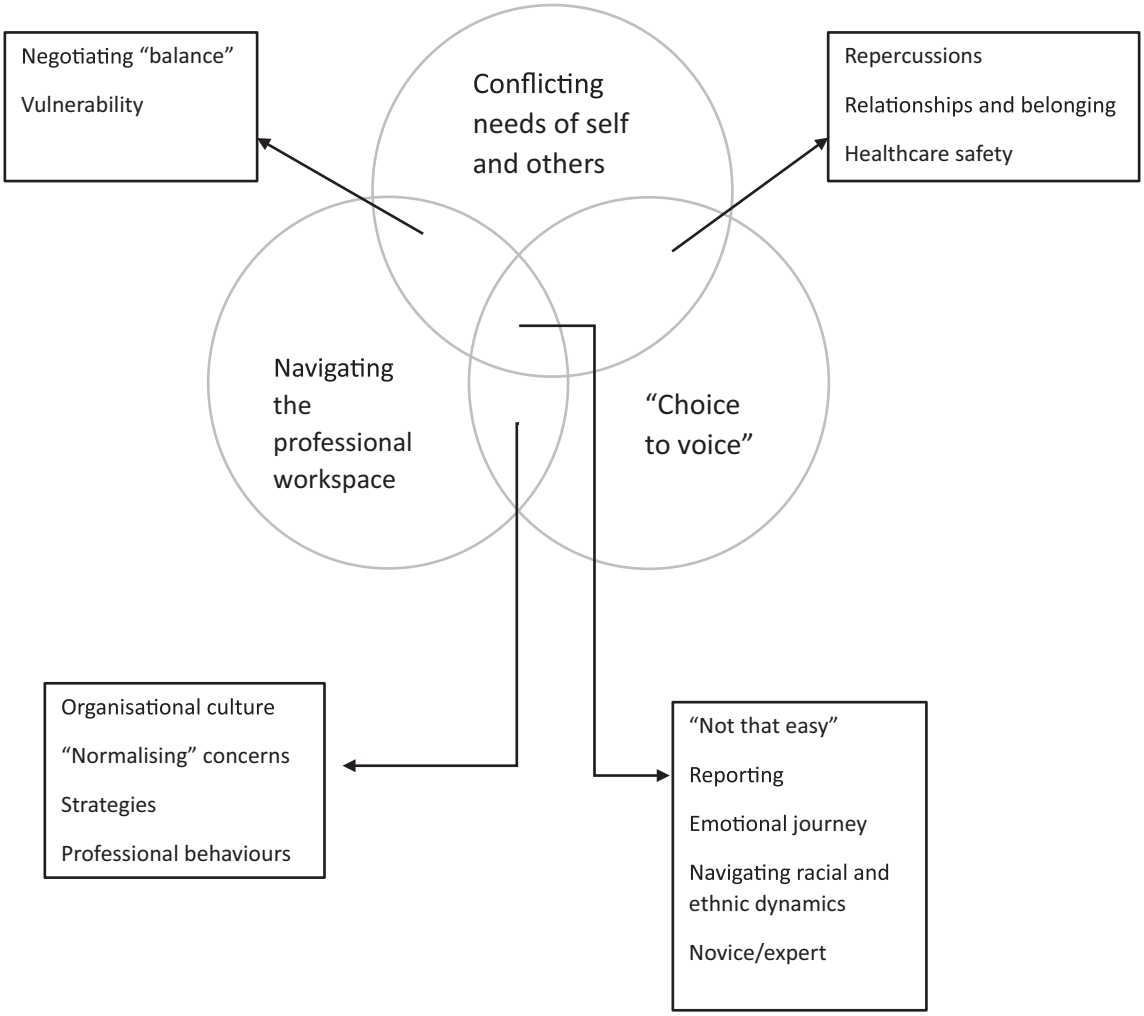

FIGURE 2 | Theme map.

of worms' (Blowers 2016, 2018) characterise a complex experience with ongoing effects and/or impacts. Complicated practice situations (Blowers 2016, 2018) and the ability to recognise a cause for concern as a novice student (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019) may impact students' confidence to speak up. It is not clear how stage of training impacts level of difficulty experienced when speaking up; while second- and third-year students may find addressing an issue with more senior staff more difficult than those in lower years of study (Groothuizen 2020), the professional and moral expectation to speak up may be particularly strong among third-year students (Fisher 2017; Fisher and Kiernan 2019).

3.3.1.2 | **Negotiating 'Balance'.** In deciding whether to speak up, students negotiate a balance between their own needs, and those of others (Blowers 2016, 2018; Groothuizen 2020; Craig and Machin 2020; Cooper 2020; Fisher 2017; Fisher and Kiernan 2019). This process of negotiating needs is characterised in one study as a 'tightrope of wanting to do right by everyone, but also having to think about yourself and the repercussions' (Walker et al. 2024). Patient advocacy appears to be a motivator for students to voice their concerns (Blowers 2016, 2018; Jack et al. 2021, 2020; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020). Students in two studies identified that despite the possibility of negative repercussions, the need to advocate for their patient would motivate them to speak up (Jack et al. 2021, 2020; Fisher 2017; Fisher and Kiernan 2019). Interpersonal risk also appears to present a barrier to speaking up; concerns for the feelings of others (Groothuizen 2020; Cooper 2020), not wanting to 'hurt feelings' (Blowers 2016, 2018) maintaining positive relationships and fitting in with the team (Groothuizen 2020; Craig and Machin 2020) suggest a process of balancing the potential impacts of speaking up or remaining silent.

3.3.1.3 | **Emotional Journey.** The speaking up experience involves negative emotions such as difficulty and distress (Blowers 2016, 2018), guilt (for both reporting and not reporting) (Groothuizen 2020) and discomfort (Fisher 2017; Fisher and Kiernan 2019) in addition to positive feelings after verbalising concerns (Cooper 2020). This journey requires emotional strength (Cooper 2020) and was felt to be 'hard', requiring resilience (Blowers 2016, 2018), or a sense of forcing oneself to be vocal about issues (Rees et al. 2024). Experiencing support from academic and practice staff is associated with positive feeling; however, awaiting feedback, having unanswered questions and unresolved emotional upset may negatively impact students experience (Cooper 2020). Receiving emotional support and practical feedback from staff, other students, and the organisation throughout the speaking up journey is important for students'

wellbeing (Cooper 2020). Peers may also be a useful support mechanism, alongside an explanation of the support offered by university settings (Blowers 2016, 2018). Feelings of fear may cause students to avoid speaking up (Blowers 2016, 2018), and fear of reprisal or retribution for raising concerns may be experienced (Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020). Fear was perceived within everyday learning experiences (Groothuizen 2020) and extended to formal reporting (Blowers 2016, 2018). Students perceive that they would report concerns but would feel the impact of fear as a result of this (Walker et al. 2024). However, students' fear may be overcome by a sense of professional and moral responsibility (Groothuizen 2020; Cooper 2020), suggesting that developing their sense of professional and personal values may support students in overcoming fears associated with speaking up.

3.3.1.4 | Healthcare Safety. Concern for the safety of patients may be a significant motivator for students to speak up (Blowers 2016, 2018; Cooper 2020; Fisher 2017; Fisher and Kiernan 2019). Despite balancing the needs of self and others, feeling concerned about patients' well-being may ease the perceived moral difficulty of deciding to raise a concern (Cooper 2020) as students perceive patients' needs ought to come first (Blowers 2016, 2018). Students may report patient safety concerns despite awareness of potential negative repercussions (Jack et al. 2020, 2021). Students may perceive that they would speak up 'in the moment' if there was risk of immediate harm to the patient (Fisher 2017; Fisher and Kiernan 2019), suggesting a perceived sense of immediacy in speaking up in this circumstance.

3.3.1.5 | Relationships and Belonging. Students' experiences and perceptions of speaking up may be impacted by relationships with others and a sense of belonging to practice teams. Whether these factors are enablers or barriers to raising concerns appears to involve complex interactions and group dynamics. Positive team dynamics and mentor relationships may enable students to raise concerns (Blowers 2016, 2018); however, familiarity, concern over interpersonal impacts and intimate working relationships may hinder the ability to speak up, or prevent action when issues are raised (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019). A sense of conflict over the choice to report may be exacerbated where University Staff also work clinically within placement areas (Okiki, Giusmin, and Hunter 2023). Similarly, students may 'weigh up' relationships with mentors against the risks of raising concerns about their practice (Blowers 2016, 2018; Groothuizen 2020). The desire to fit in may also lead students to conform to negative team dynamics, such as joining in with inappropriate behaviours (Groothuizen 2020). A perceived 'outsider' status characterised by feelings of not fitting in or lack of belonging, may also present a barrier to speaking up (Craig and Machin 2020; Groothuizen 2020). However, leadership may be an indicator for whether students feel empowered to speak up (Craig and Machin 2020), suggesting that leadership is a potential enabler for overcoming the barrier of perceived outsider status.

3.3.2 | Navigating the Professional Workspace

3.3.2.1 | Vulnerability. The vulnerability of the student position in speaking up was evident across the included studies (Blowers 2016, 2018; Craig and Machin 2020; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020). The uncertainty experienced in response to receiving mixed reactions to concerns places students in a vulnerable position as they are still a student, not yet a registrant (Fisher 2017; Fisher and Kiernan 2019). Similarly, students may perceive that even if they do speak up, staff members hold more power (Walker et al. 2024) and have a greater ability able to influence the opinions of other staff (Okiki, Giusmin, and Hunter 2023) Students are vulnerable to the opinions and responses of others (Blowers 2016, 2018) and fear of being 'labelled' as a troublemaker prevent speaking up (Fisher 2017; Fisher and Kiernan 2019). Power and influence over students' situations impact their ability to speak up with concerns (Blowers 2016, 2018) or improvement ideas (Craig and Machin 2020). Perceived hierarchy may also exacerbate vulnerability, with students stating that it would be 'scary' to challenge the manager (Walker et al. 2024) or doctor (Groothuizen 2020) and feeling vulnerable when challenging non-qualified staff such as health care assistants due to their established and experienced status (Fisher 2017; Fisher and Kiernan 2019). This may suggest that while hierarchical structures may inhibit the ability to speak up, steep authority gradients may also act as a barrier. Students are aware of power differentials related to their position, charachterised as having to do 'whatever you can within the limits of what power you've got' when navigating speaking up situations (Walker et al. 2024).

3.3.2.2 | Novice/Expert. Students' inexperience may result in reluctance to speak up, particularly where a concern involves challenging senior or experienced staff or when students compare themselves with the 'expert' status of others (Groothuizen 2020; Fisher 2017; Fisher and Kiernan 2019). Perceptions of age may also impact speaking up as students perceived being young may make it more difficult to have the confidence and courage to challenge others (Groothuizen 2020). Students may also perceive that young age is associated with less experience and greater age associated with being 'higher up the hierarchy' (Groothuizen 2020; Fisher 2017; Fisher and Kiernan 2019), and therefore perceive their age as a barrier. Inexperience, complex practice situations and doubts about their own knowledge base may also lead students to question whether their concern is legitimate, leading to reluctance to challenge due to fear they may be wrong (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019). This uncertainty in judging the appropriateness of practices was felt even by more senior students (Fisher 2017; Fisher and Kiernan 2019). Further difficulty is experienced where the student's view is not shared by other team members (Blowers 2016, 2018), suggesting that the novice status or assumed inexperience of students presents a barrier to speaking up.

3.3.2.3 | Strategies. The speak-up strategies that students employ indicate a sense of caution. Upon feeling something is not right, students may 'check it out' to validate their concern (Cooper 2020). This may be linked to hesitance owing to novice status and doubts about their own knowledge base (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019). Where concerns are raised but unheard, students may 'relay' or 'escalate' their concerns to others until an appropriate response is made (Cooper 2020; Groothuizen 2020). Students may also avoid confrontation, using gentle and tactful approaches to speaking up (Blowers 2018, 2016), such as seeking physical help, advising,

prompting, verbalising worries or anxieties to bring concerns to the attention of others (Cooper 2020). Students may also employ conflict avoidance strategies which present a barrier to speaking up, such as staying quiet, ignoring behaviour or being numb to emotions (Rees et al. 2024). Students may also draw attention to a concern by asking practice questions, even where they are aware of errors being made (Blowers 2016, 2018; Cooper 2020), suggesting that students may speak up by using their novice status to query practice. Accordingly, a learning environment where questioning is accepted as routine learning may enable students to speak up (Blowers 2016, 2018).

3.3.2.4 | Organisational Culture. Students do recognise and report culture issues such as negative behaviours and attitude (Fisher 2017; Fisher and Kiernan 2019); however, in cultures with steep hierarchy/authority gradients, students fear retribution and may not feel able to speak up (Groothuizen 2020), suggesting that negative cultures present a barrier to speaking up. Conversely, organisational recognition that raising concerns is acceptable if in good faith may enable students to speak up about concerns (Cooper 2020). Team culture also influences students' ability to speak up, with open learning environments being positively associated with speaking up and negative relationships with mentors presenting a barrier (Fisher 2017; Fisher and Kiernan 2019). Casual, non-threatening conversations may enable students to speak up with improvement ideas (Craig and Machin 2020), suggesting that a 'shared belief that the team is safe for interpersonal risk-taking', a concept known as 'psychological safety' (Edmondson 1999), may be an important enabler.

3.3.2.5 | Professional Behaviours. Students widely acknowledge that speaking up and raising concerns is a professional requirement and obligation (Cooper 2020; Jack et al. 2021, 2020; Fisher 2017; Fisher and Kiernan 2019; Blowers 2016, 2018; Groothuizen 2020). This sense of professional duty may act as a motivator to overcome barriers to speaking up (Cooper 2020; Blowers 2016, 2018; Groothuizen 2020), and may increase as students' progress through their training, with more senior students feeling greater obligation to raise concerns (Fisher 2017; Fisher and Kiernan 2019). Despite recognising their professional obligations, students recognise that speaking up involves personal challenges (Groothuizen 2020) and requires courage (Blowers 2016, 2018). Conversely, students can sometimes be coerced to participate in practice that is not in line with good practice, legislation and professional behaviour/s (Fisher 2017; Fisher and Kiernan 2019). Learning skills to speak up in a professional manner may enable students to speak up appropriately about their concerns (Blowers 2016, 2018).

3.3.3 | 'Choice to Voice'

3.3.3.1 | Repercussions. Students perceive that speaking up or raising concerns may have personal repercussions. These include a consequential impact on placement grading or marks (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020), damage to relationships (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020) and impact on reputation or 'blacklisting' (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019). Concern that reputational damage may follow students through their ongoing training may potentially complicate their decision to speak up, particularly where concern for placement grading/success is felt. However, students may perceive that they would still raise a concern despite expecting negative repercussions (Jack et al. 2020, 2021).

3.3.3.2 | Reporting. Reporting experiences were mixed. Students may be aware of their university's feedback systems and who to approach if they have a concern and feel largely confident that they would receive support from their university if they were to raise a concern about their placement learning experience (Jack et al. 2020, 2021). However, students may not know the routes for reporting concerns (Okiki, Giusmin, and Hunter 2023), or perceive the reporting system as 'designed to avoid having to take what you're saying on board' (Walker et al. 2024), suggesting systemic barriers may impact the students decision or ability to raise concerns. Students may be unlikely to report incidents, or may feel that incidents that are reported are not dealt with adequately (Hallett, Wagstaff, and Barlow 2021), and may know of students who have witnessed incidents of concern and not reported these (Jack et al. 2020, 2021). Student experiences of reporting in clinical versus hospital environments are mixed. While students may have more positive experiences of reporting to their academic institution as opposed to the clinical manager or hospital (Walker et al. 2024). Students may be more likely to report incidents to mentors, and less likely to report to academic staff (Hallett, Wagstaff, and Barlow 2021). Strengthening links and enhancing communication between clinical staff and academic staff could support identification of speaking up issues. However, students may perceive or experience that 'nothing will be done' as a result of raising concerns (Okiki, Giusmin, and Hunter 2023; Walker et al. 2024; Hallett, Wagstaff, and Barlow 2021; Jack et al. 2020, 2021). Students may not experience satisfactory or meaningful outcomes following the reporting of an incident (Walker et al. 2024; Jack et al. 2021, 2020; Okiki, Giusmin, and Hunter 2023), highlighting the importance of closing feedback loops after a concern has been raised. Increased personal assertiveness due to having prior care experience may initially be an enabler for speaking up about concerns (Field-Richards et al. 2024).

3.3.3.3 | 'Normalising' Concerns. Students may 'normalise' their concerns by justifying suboptimal care (Jack et al. 2021, 2020), rationalising failures to act (Blowers 2016, 2018), or accepting incidents as occupational hazards (Hallett, Wagstaff, and Barlow 2021). This acceptance may be informed by the perceived 'ubiquitous' nature of the incidents and copying the behaviours of experienced staff (Hallett, Wagstaff, and Barlow 2021). An additional barrier may also be presented by placement support teams, who may not encourage students to report incidents if they are viewed as 'part of the job' (Hallett, Wagstaff, and Barlow 2021). One study finds that previous care experience may be both an enabler and a barrier for recognising and reporting care concerns as while prior experience may enhance students' ability to recognise suboptimal practice, it may also lead to an increased tolerance threshold thus reducing the likelihood of recognition and reporting (Field-Richards et al. 2024).

3.3.3.4 | Navigating Racial and Ethnic Dynamics. Three papers suggest that racial or ethnic factors may impact on students' decision to speak up, and also may impact their experience of speaking up (Rees et al. 2024; Walker

et al. 2024; Okiki, Giusmin, and Hunter 2023). While students acknowledged a moral responsibility to speak up about racism (Walker et al. 2024), they also conveyed that 'it's really difficult, but [it] needs to be addressed' (Rees et al. 2024). Students overtly discussed their anxieties in raising concerns regarding racism; 'I didn't want to stick out like "oh my god, it's the black issue and this is, this black person raising this issue" (Okiki, Giusmin, and Hunter 2023), suggesting that perceptions of self and the potential reactions of others may impact the decision to speak up about these issues'. Some discussed how they felt unheard to in comparison with white peers; 'I think, we're so used to letting, or allowing, Caucasian people to speak up more than we do just in case we don't get listened to' (Okiki, Giusmin, and Hunter 2023). In addition to overt racism, students also highlighted experiencing unconscious bias related to culture, race and ethnicity in how they are perceived when speaking up; 'Maybe it's because I'm [Asian] and we're seen as quite subservient. I'm also a woman [...] she looked at me and said "interesting" and finished the conversation, she was like "it's probably time to go"' (Rees et al. 2024).

4 | Discussion

The findings of this review suggest that raising concerns and speaking up in the context of pre-registration education and training is a complex social phenomenon, impacted by a blend of individual, interpersonal and institutional factors. As concepts, speaking up and raising concerns during pre-registration training are dynamic, non-linear and difficult to define; however, students' decision to speak up appears to be influenced by factors related to their student status. Students often recognise that speaking up is 'the right thing to do' but are also aware of potential impacts that may occur as a result of speaking up during their training to become a registrant.

Where a number of studies in this review related to specific incidences of concern, including aggression, bullying and harassment and care concerns, the wider definition of 'raising concerns' is much broader. The National Guardian Office (NGO) defines speaking up as having '*no limitations – it is about anything that gets in the way of patient care and worker well-being*' (National Guardian's Office 2024). As a necessary antecedent to speaking up, students should be supported to first *recognise* incidents or conditions of concern, as students may justify, rationalise or normalise sub-optimal practices (Jack et al. 2020, 2021; Blowers 2016, 2018), and this may be reinforced by placement staff who may view such situations as 'occupational hazards' or 'part of the job' (Hallett, Wagstaff, and Barlow 2021). These findings are echoed in the Welsh context by Brown, Jones, and Davies (2020), who also find that students may not speak up due to perceiving sub-optimal situations as widely practiced or 'ward ethic'. This highlights the importance of assisting students to recognise that cultures of acceptance may be an indicator of weak safety culture, warranting speaking up. Similarly, students require support to gain confidence in their own ability to recognise a concern (Fisher 2017; Fisher and Kiernan 2019; Blowers 2016, 2018), a finding reflected in other qualitative studies conducted in Australia (Fagan, Lea, and Parker 2021a) and in previous systematic reviews (Milligan et al. 2016).

Patient safety and advocacy appear to be strong motivators for students to speak up and may prove strong enough to overcome fear of repercussions (Cooper 2020; Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Jack et al. 2021, 2020). This resonates with findings from outside of the English setting (Bickhoff, Levett-Jones, and Sinclair 2016; Zhu et al. 2019; Ion et al. 2015) and also in studies involving registrants (Schwappach and Gehring 2014). However, in concerns related to clinical judgement, the 'novice' student status against registrants 'expert status' may present a barrier to speaking up. Concerns relating to clinical judgements may be complicated by the experience and expert status of others, impacting students' confidence and potentially causing hesitance in speaking up (Groothuizen 2020; Fisher 2017; Fisher and Kiernan 2019; Blowers 2016, 2018). While professional roles may present a hierarchical barrier and cause students to fear speaking up (Groothuizen 2020; Zhu et al. 2019), authority gradient can present outside of typical professional hierarchies—for example, students felt vulnerable when challenging non-qualified staff such as health care assistants (Groothuizen 2020; Zhu et al. 2019; Fisher 2017; Fisher and Kiernan 2019). Open cultures may support students to question practices as part of their routine learning, but this may be largely dependent on wider safety and learning cultures within teams and organisations. Creating safe and effective learning environments where students can speak up openly as part of everyday learning appears to be an important factor in supporting students to speak up as part of everyday business.

While fear or concern over negative impacts on placement grading may impact students' decision to speak up (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020), a good relationship between students and mentors/teams can positively influence the decision to raise a concern. Equally, negative relationship(s) may present a barrier to raising concerns at any level (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Cooper 2020). Relationships may also be indicative of environments; effective relationships between students and mentors appear to be linked with a positive learning environment where students can raise concerns directly with mentors, and conversely an unsupportive relationship may lead to a hostile learning environment and fear of repercussions (Brown, Jones, and Davies 2020). Complexities may occur when staff work across clinical and university settings (Okiki, Giusmin, and Hunter 2023) suggesting a need to be mindful of the impact student-staff dynamics on the decision to speak up about issues of concern. In the context of nursing and midwifery, supervision and assessment were separated in the new NMC standards for education and training 2018 (Nursing and Midwifery Council 2023). It has been previously argued this separation of supervision and assessment is beneficial to the student–supervisor relationship as it will not be influenced by assessment (Uren and Shepherd 2016). However, the extent to which the separation of supervision and assessment has been beneficial in supporting students to speak up during their training remains unclear.

This review affirms other UK and international study findings, namely that students fear reprisal when raising concerns, particularly in relation to negative impacts on relationships and belonging, learning experiences and academic progression (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Jack et al. 2021, 2020; Groothuizen 2020; Brown, Jones, and

Davies 2020; Fagan, Lea, and Parker 2021b; Bickhoff, Levett-Jones, and Sinclair 2016). Students may perceive that their wider and ongoing reputation may be impacted as a result of raising concerns, and students may both perceive and experience being negatively labelled or excluded by others due to speaking up (Fagan, Lea, and Parker 2021a; Fisher 2017; Fisher and Kiernan 2019, Blowers 2016, 2018; Bickhoff, Levett-Jones, and Sinclair 2016; Capper, Muurlink, and Williamson 2021; Ion et al. 2015). While various factors may lead to students experiencing the need to balance the risks and benefits of speaking up about concerns, concern over interpersonal risk appears to influence the student's decision to speak up (Fisher 2017; Fisher and Kiernan 2019; Blowers 2016, 2018; Fagan, Lea, and Parker 2021b). The student's position as an 'outsider' may indeed be beneficial in bringing new perspectives and recognising issues of concern (Francis 2013); however, this outsider position may also present a significant barrier to speaking up (Craig and Machin 2020; Groothuizen 2020; Fagan, Lea, and Parker 2021a). Additional barriers may be perceived and/or experienced by students due to racial or ethnic factors (Okiki, Giusmin, and Hunter 2023; Walker et al. 2024; Rees et al. 2024) suggesting a need to address these issues in more depth in order to create inclusive and open learning environments. Team leaders play a key role in creating psychologically safe teams, and positive leadership experiences may also support students to voice improvement ideas (O'Donovan and McAuliffe 2020). The receipt of positive support from a superior being an enabler, echoes findings in the wider literature involving registrants, where open and supportive managers have been identified as key enablers for speaking up (Morrow, Gustavson, and Jones 2016).

Students may feel a sense of futility around reporting and may perceive that nothing will change as a result of speaking up (Hallett, Wagstaff, and Barlow 2021; Jack et al. 2021, 2020). This finding is echoed in other international reviews (Zhu et al. 2019; Ion, Smith, and Dickens 2017), in primary research (Courtney-Pratt et al. 2018; Violato 2022) and also in studies involving healthcare workers (Morrow, Gustavson, and Jones 2016). Akin to international findings that students experience a sense of fear around speaking up (Hoffmann et al. 2022; Fagan, Lea, and Parker 2021b; Ben Natan et al. 2017), this review also finds that fear presents a significant barrier for students in deciding whether to raise a concern (Blowers 2016, 2018; Fisher 2017; Fisher and Kiernan 2019; Groothuizen 2020). This sense of fear, alongside the perception that speaking up will not change the situation may make it even more difficult for students to speak up. Strategies such as 'closing the loop' and ensuring that those who speak up receive feedback related to their concern may assist in overcoming this significant barrier.

To manage perceived risks, students may adopt conflict avoidance strategies (Rees et al. 2024) and gentle or tactful approaches such as questioning (Blowers 2016, 2018; Cooper 2020). This is also evident in two Australian studies, where students indicated that asking a question was the best approach to speaking up (Fagan, Lea, and Parker 2021b), or they 'played the student card' to avoid negative consequences of speaking up (Bickhoff, Levett-Jones, and Sinclair 2016). Inquiries and investigations into healthcare disasters often uncover early warning signs or 'weak signals' that were missed or discounted (Macrae 2014). As students are often well placed to provide a fresh perspective (Francis 2013), these 'soft' methods for raising concerns may highlight a need to be aware of weak signals indicating suboptimal care or emerging risks. Encouraging mentors and supervisors of students to be aware and alert to these speaking up strategies may strengthen awareness among mentors and staff.

Students identify that speaking up requires courage (Blowers 2016, 2018) and strength (Cooper 2020; Ion et al. 2015), and may be enabled by peer support (Cooper 2020; Ion et al. 2015; Blowers 2016, 2018). While students require comfort and support throughout their speaking up journey (Cooper 2020), this review identified little evidence to suggest what general support strategies may be deemed most useful for students. It is noted that one medical school in the north of England has embedded two Freedom to Speak Up guardians for undergraduate and postgraduate students; however, this review did not locate any primary data to ascertain the impact of this role on supporting students to speak up, suggesting that this is an area for further investigation. Findings from international studies suggest that dedicated 'speaking up' education sessions may improve students' confidence when confronted with challenging situations (Hanson et al. 2020), and simulation may also be a useful learning modality to support students in developing skills and confidence to speak up (Violato 2022; Aul, Ferguson, and Russo 2023; Da Silva et al. 2020).

5 | Conclusion

The review suggests that in speaking up, students experience dissonance due to the conflicting needs of themselves and others. While patient safety was found to motivate students to raise concerns, their decisions on speaking up may be influenced by students' relationships with others in the training environment. Students navigate through the professional workspace; they are aware of the professional requirements of their role, but experience vulnerability associated with the novice status and inexperience associated with the student position. Students may face additional barriers due to race or ethnicity. When speaking up about any concerns, students may employ gentle or tactful strategies to manage potential conflict. Upon recognising a concern, fear of perceived or actual repercussions may inhibit the student's ability to speak up. Concerns may also be normalised or justified, both by students and practice teams. Open cultures within teams and organisations, alongside support and feedback may enable students to overcome perceived and actual barriers to speaking up.

5.1 | Barriers and Enablers

The complex and dynamic nature of the factors that influence the speaking up/raising concerns journey reinforce the need to assess, understand and monitor healthcare systems and associated interventions in context. Difficult emotions—notably fear, interpersonal risk, hierarchical structures with steep authority gradients and the assumed inexperience of students—present barriers to speaking up during pre-registration training. To overcome these barriers, supportive leadership could identify and empower the underpinning motivations (e.g., advocacy and patient safety) that underpin students' willingness to speak up about concerns. Open learning cultures as part of everyday learning experiences can contribute to wider aim of making

'speaking up as business as usual', supporting students to recognise and raise concerns as part of normal practice.

5.2 | Implications for Practice

Pre-registration students have a moral and ethical compass which could be harnessed and used as a catalyst for speaking up about concerns, creating learning environments which enable students to develop these skills may strengthen these values and support the next generation of health and care staff to develop the skills and awareness needed to make speaking up 'business as usual'. When concerns are raised by students, the complexity and impacts of the speaking up experience should be recognised and adequate ongoing support offered, including communication of ongoing actions and feedback. Practice and education staff in academic and clinical environments should be aware of the role of group conformity and social identity in the training of health and social care students and remain vigilant to the chance that where students may normalise concerns or sub-optimal factors, this may indicate a need to explore the culture and practices of the system further. Racial and ethnic dynamics may present additional barriers that should be explored and addressed. Additionally, it is important to be aware of the gentle or non-confrontational ways that students may question sub-optimal practices, remaining mindful that this may be used as a mechanism to speak up about concerns. In these cases, amplifying these 'soft signals' may contribute to wider safety and learning cultures in health and social care systems. Findings of this review may also inform local or national policies, highlighting the importance of considering the specific needs and experiences of pre-registration students in the context of speaking up.

5.3 | Strengths and Limitations

A concentrated search yielded high retrievals, yet a small number of articles were identified for inclusion. This reflects the complexity and variability in the conceptualising of 'raising concerns' and 'speaking up' in health and social care, in addition to the concentrated geographical location. Despite search terms being expanded to include social work and allied health professions, the included studies largely involve participants from nursing courses. One study involved participants from speech and language therapy course and one a midwifery course. This suggests an evidence gap in relation to wider social care and allied health professions. While the findings of this review may be useful to understand the experiences of students speaking up during their training, the majority of the included studies used purposive sampling strategies and qualitative methodologies, which may limit generalisability (as is common with qualitative research). However, the qualitative data retrieved enabled a deep insight into student perceptions and lived experiences of raising concerns and speaking up.

Acknowledgements

The authors thank Alisen Dube and Yetunde Ataiyero for their advice and support.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that supports the findings of this study are available in the supporting information 1 of this article.

Peer Review

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16751.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.