Safety culture programme group (SCPG) report

Overview of safety culture discovery and discussions 2021

NHS England and NHS Improvement

Contents

Introduction

1. This report contains an overview of the discussions undertaken by the Safety culture programme group (SCPG) in 2021. It also includes their recommendations so that safety culture continues to be developed as one of the foundations that underpins the NHS patient safety strategy.

2. Please note that the measurements and interventions reported here are not intended to be a comprehensive list, and one of the recommendations is that further guidance on both safety culture measurements and interventions will be developed and shared in future.

Safety culture programme group (SCPG)

1. The Safety culture programme group (SCPG) was a virtual task and finish group established in July 2021 for six sessions to provide recommendations to support and enable organisations to improve their safety culture through embedding a continuous cycle of understanding the issue, developing a plan, delivering the plan and evaluating the outcome with an underpinning foundation of inequalities reduction.

2. The group of 31 participants contained patient safety specialists from each region which included representatives from all sectors of the NHS eg mental health, community, ambulance and primary care services. There were also representatives from NHSEI and those with specific expertise in safety culture, culture and transformation and psychological safety. This also included specific representation from the National maternity and neonatal safety improvement programme which links to the Maternity transformation programme and includes a workstream focused on safety culture in maternity. The group also included three patient safety partners who provided invaluable insight, ideas, and challenge.

3. Diversity inspires creativity and drives innovation. The diversity of the group was reviewed against the nine protected characteristics. 70% of the group responded and where possible and/or relevant, information was compared to National data. The group was approximately representative for gender and sexual orientation (ie demonstrated a similar range of percentages in comparison to national data). However, the group was not representative in relation to ethnicity as it was predominantly white 90% (in comparison to 78% from NHS workforce 2020 data) and not representative of religion as it was mostly of no religion 55% (in comparison to 25% from 2011 Census data). The ages ranged from 25 to 69.

4. Co-production was enabled using a variety of online tools including: Jamboard, Menti and Mural, and the outputs from these shared with the group. To facilitate

interaction the group also shared their background and experiences via a shared "About me" document.

5. The group agreed the following definition of safety culture:

Positive safety culture is one where the environment is collaboratively crafted, created and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- *Continuous learning and improvement of safety risks*
- *Supportive, psychologically safe teamwork*
- *Enabling and empowering speaking up by all*

6. Successful outcomes for safety culture improvement were identified as:

- Continuous learning and improvement
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all
- Compassionate, just, restorative care for all
- Open and transparent communication
- Inclusive and respectful civility
- Visible caring leadership
- Diverse co-production

Safety culture discovery themes and priorities

1. Eight themes were identified for review and action and prioritised as ordered in table 1.

Table 1: Safety culture themes and ideas

Theme priorities	Summary of ideas
Definition	There should be a clear operational definition of safety culture. This should be short, succinct and connect to the shared purpose/vision. This should be an inclusive definition.
Team working	The focus should be on teams as the seat of safety culture where we see it as a social construct. We should consider how teams have redesigned themselves during the pandemic. There should be a focus on civility and recognise the overlap with other programmes such as compassionate leadership. It is important to bring together quality improvement and patient safety teams within organisations and enable role modelling by leaders. Leaders should be provided with training to facilitate their safety culture understanding eg via Patient Safety Syllabus – training available online free to all for levels 1 and 2. There should be a focus on psychological safety.
Improvement and learning	With a focus on learning from good practice when things go well in everyday work, we should foster place-based learning cultures. Regional quality improvement hubs are being developed to support training in improvement and should be especially supportive to primary care. We should develop an appetite for improvement. There should be more emphasis on success and celebration. What we do and focus on affects safety culture, so we should demonstrate more positive focus on learning and celebrating success.
Establishing a safety system	We should seek to understand behaviours and their contexts, create structures and establish processes to support safety after harm has occurred and where there is the most potential for learning. We should reward Just culture implementation and provide peer and psychological support for all those affected by safety incidents eg NHS Resolution Being fair. Teams and organisations should be free to determine their own ways

Theme priorities	Summary of ideas
	of measuring safety culture. We should embed safety systems thinking so that we move away from an obsession with incidents towards establishing a hazard spotting approach.
Practical focus	We should identify relevant, simple safety culture interventions for people to use. The patient safety syllabus (levels 1 and 2) should be part of mandatory training. Restorative practice should be better understood and embedded within healthcare. The Just culture guide should clarify what is just for patients and families when harm has occurred, for example the AvMA - Harmed patient pathway. We should emphasise that encouraging speaking up is a fundamental part of safety culture and that removing barriers that prevent this are key. NHSE&I should focus on their own culture as well as that in the system. Each organisation should have a safety culture champion trained via Patient Safety Syllabus – training available online free to all for levels 1 and 2. To help put training into practice team coaching and mentoring support are recommended. We should provide guidance on how to understand and change safety culture. We could identify pilot sites to test suggested changes. Safety culture measurements should not be seen as key performance indicators.
Human factors	We should recognise that human factors and systems thinking in fundamental to safety culture. We should have more embedded human factors practitioners working collaboratively with clinicians.
Co-production with patients/ carers	Co-design with patients, families and carers should be inherent to all healthcare projects, including within safety culture work. Patient safety partners should be as diverse as possible and situated at all levels of an organisation. The patient safety syllabus should be available/accessible to patients. There should be regular processes for patient/family feedback to inform improvements and understand the patient perspective of safety culture.
Appreciating complexity and layers	We should enable everyone to understand their shared role in creating culture and that it is part of a complex system. We should not see culture in isolation. Safety climate sits at different levels: micro, meso, and macro. We should address the conditions required for a good safety culture, this is not just about staff.

Safety culture improvement change ideas

1. Ideas for safety culture improvement were identified, reviewed and ranked, as shown in figure 1.

Figure 1: Ranked improvement ideas for safety culture change

1. Training in the principles of Just culture and honest and constructive feedback
2. Create opportunities for safety culture discussion and conversations at team level, with mentoring and resources support
3. Co-production of patient safety improvement with patients, carers, and families
4. Leadership development to enable leaders to understand and role model good behaviours
5. Training in human factors & ergonomics to underpin responses to patient safety incidents
6. Safety culture champions
7. Team development of rules, behavioural norms, and aspirations with template provision
8. Provision of safety culture measurement tools and interventions
9. Fully supporting staff, patients and carers involved in incidents to heal afterwards, with training, signposting, communicating and involving them in the learning response process
10. Speaking up training and communication tools, increase number of speaking up champions
11. Shared patient records and appropriate access by staff, patients and carers via digital and other media
12. Create multiple ways to gather feedback from staff, patients and carers and then identify and publish the improvements

2. Further work was undertaken to generate targeted safety culture improvement change ideas as shown in table 2.

Table 2: Targeted safety culture improvement change ideas

Patient involvement	**Primary care: dental health**
• Most primary care practices already have patient participation groups that can be engaged • Patient safety partners • Use understandable terms and visual aids • Listen actively with empathy when patients raise concerns • Actively support patients/families in the learning response process following a patient safety incident • Linking with the voluntary sector eg via PCNs and social prescribing • Co-production of patient safety and other work • Use of text messaging (via AccuRx) in primary care enables patient feedback • Be aware/inclusive of the diversity of the community • Gain patient views as data eg patient incident recording • Involve patients in the diagnostic stage of organisation's culture assessment • Promote healthy challenge with patient involvement enabling psychological safety for all	• Raising awareness and improving education around why to report incidents and how to discuss and analyse them in a constructive learning way • Move away from targets/NHS remuneration model based on activity – towards NHS dental contract reform • Early education and training on patient safety starting at undergraduate level • Understanding of appointment time allocation • Promoting the use of Learn from patient safety events (LFPSE) to support transition from local to system level learning • Support system/networks for staff who have been involved in a patient safety incident • Using personal stories of lived experience (from staff and patients) to engage and raise awareness around safety culture and its importance • Stakeholder including regulators to move away from blame/fear culture towards supportive learning

• Supporting patients to record patient safety incidents and be involved in the learning response process • Enable patient feedback • Involve patients in SEA meetings • Ask patient and carers to be partners in safety with brief explanations to help understanding • Involve the patient as part of the treatment/care planning • Understand what patient safety means to patients and how they feel they can be involved • Include patients as part of leadership walkarounds	• Shared integrated care and medical history which can be seen by dental team - requires digital connection and interoperability • Modify existing safety culture interventions for use in primary care settings • Training or CPD patient safety sessions specific to dentistry linked to HEE patient safety syllabus
Primary care: GPs • Most primary care practices already have patient participation groups that can be engaged • Improved communications to patients about what we do well and what we are improving • Review how to engage with patients who are reluctant to take medication • Encourage patients to take their own notes during a consultation • Joint training opportunities with staff and patients	**Ambulance service** • Awareness and self-reporting opportunities • Recognising that harm to patients is not just about harm when directly in ambulance care • Value patient safety partners and other patient representatives and the experience they can offer to help change culture and learn • Holistic patient journey
Primary care: Community pharmacy • Encourage feedback on consultations • Promoting incident self-reporting	**Inequalities** • Monitor BAME staff disciplinaries in relation to incidents – review by Exec

• Consider patient safety review at PCN/ population footprint	• Review BAME maternal deaths

Safety culture interventions and tools review

1. The draft safety culture guide contains six key elements of safety culture with 18 safety culture interventions and tools described that underpin these. The Safety culture programme group (SCPG) reviewed the 18 interventions to provide assurance on relevance, efficacy, resource requirements and to identify areas of concern and suggest other relevant ideas.

2. Each intervention was scored as to whether the group felt it was relevant and useful (see utility score) and comments were captured from the reviews to better understand any issues and implementation needs. It was noted that a number of these interventions were not relevant to primary care and other services and so further work would be needed in these areas.

3. Please note that the interventions reported here are not intended to be a comprehensive list, and one of the recommendations is that further guidance on safety culture interventions will be developed and shared in future.

4. Interventions to enable or enhance safety culture require a shift in being, not solely a process of implementation. Behaviours that support this are key to effective improvement and the importance and complexity of the relational aspects of change should not be underestimated.

Leadership

- Initiate leadership walk rounds: This approach involves leaders conducting regular visits to different parts of their organisation, to hold informal discussions with frontline staff about safety issues and signal on ongoing commitment to creating a culture of safety and improvement [19]. This can foster deeper understanding and trust between leaders and teams.
- Feedback: Utility score 5/6. Comments: these actions will increase pressure on under resourced staff, should include all levels of the organisation, needs to include patients, and be supported by safety culture champion, will staff raise issues with a senior leader? Needs to be supported with open questions.

- Safety and quality boards: This is a way to show learning from past activities and improvement projects. It is typically a poster board displayed on the ward with sections that may include: opportunities, actions, and outcomes. They allow leaders, staff, patients and carers to be open and curious about the work in a ward or department, provide valuable information about what is happening, identify a key point of contact on the ward and [20] help leaders take action where relevant [12].
- Feedback: Utility score 7/9. Comments: Can be onerous to keep up-to-date, team need to feel empowered, often out of date information, how would this work in primary care/community etc?
- Identify safety champions: Trust-level Patient Safety Specialists were appointed in 2020/21 in NHS trusts across the country [3]. Patient safety partners [21] will be appointed in trusts during 2022 to enable improvement by co-production. Local-level volunteer champions, in individual departments for example, can be an additional resource that helps to demonstrate to staff and patients the importance of safety at all levels.
- Feedback: Utility score 6/13. Comments: should be clinical and non-clinical staff, does this detract from patient safety being everyone's business? Shows visible commitment to patient safety, all job descriptions should include patient safety. Use patient safety partners
- Other suggestions: Understanding organisational safety culture as described at Board (WAI) vs. how it feels to individuals in the workplace (WAD).

Continuous learning

- Learning from Excellence: get started in your team using resources from the Learning from Excellence website [23] and use the appreciative inquiry framework [24]to support you to dig deeper into episodes of excellence.
- Feedback: Utility score 6/10. Comments: Do staff have the resources to do this? need system to capture data, need to get investigations right before starting this journey, need to emphasise this as much as incidents.
- Promote the importance of embedding human factors and ergonomics practitioners: use the understanding of how people interact with their environment to better understand how system design can impact human performance [27,28]
- Feedback: Utility score 5/7. Comments: Will observations impact on patient care? How would this be practically achieved? What tools should be used?

Observations will create understanding of work as done, rather than as imagined.

- Discover the risks in your services: use techniques like process mapping and proactive hazard analysis to identify risks within services before they lead to harm to patients [29,30].
- Feedback: Utility score 7/9. Comments: staff would need to understand how to do this and have quality improvement training. Unsure that staff have the capacity to do this? Process maps are useful though rarely capture the reality or complexity of the work. Would need to have clear timescales for actions.
- Other suggestions: IHI global trigger tool, Quick guide for SEA (NHS Scotland), use of PDSA routinely to test and learn, use of data from GIRFT, HSIB, use evaluation approaches that assess for behaviour change

Teamworking and communication

- Kickstart a conversation about working safely: The Sign Up to Safety Campaign developed a set of 10 questions to help you and your colleagues kick-start a conversation about working safely. Use the Kitchen Table approach [34] to initiate an open and honest conversation. Use the "Tools to Talk" and "Just Ask Me" videos.
- Feedback: Utility score 4/4.
- Use structured feedback: Feedback is a key ingredient of the learning cycle. Give each other positive feedback, and the reasons why. Use a structured approach to giving constructive feedback, such as the Situation, Behaviour, Impact (SBI) approach [35].
- Feedback: Utility score 2/2.
- Initiate safety huddles: Use resources including the "Yorkshire Safety Huddles Manual" [36] to initiate safety huddles, starting with a single team. Some of the key ingredients to the huddle are the use of clear communication eg SBAR [37], simple data and the celebration of success [38].
- Feedback: Utility score 4/4. Comments: What information would be needed/exchanged at a huddle? Focus on the how, use for real-time feedback
- Other suggestions: Behavioural marker systems eg NOTTS, ANTS, SPLINTS, NOTECHS, Non-technical skills (Aberdeen Uni), How do you

include the patient/family perspective? Need to adapt for setting eg primary care, PROMPT obstetric training, Fierce conversations (Susan Scott), BOFF (Behaviour and impact of what I Observed and how I Felt observing the behaviours and what Future considerations should we have)

Psychological safety

- Use the NHS Just Culture Guide: this is a way to ensure that everyone is treated fairly in the event of an incident, or a near miss. The NHS Just Culture Guide is a tool to support individuals to treat staff fairly, consistently, and constructively if there is a concern relating to a patient safety incident [40].
- Feedback: Utility score 2/2. Comments: Just and restorative culture links to NHSR, need to link to broader principles of patient and family support and DoC. Requires significant training in systems and human factors to be used appropriately (Paul Stretton The 'just culture': why it is not just, and how it could be 2020)
- Safer communication: Sometimes you need to speak up, and you may feel scared to do this, there are some tools to help you feel safer. The TeamSTEPPS approach [41] provides a number of options including the assertive "CUS" communication mechanism to help you safely raise your voice in a stepped manner that clearly escalates if you think people are not listening: "I am Concerned", I am Uncomfortable", "This is a Safety issue".
- Feedback: Utility score 4/4. Comments: how to create these conversations between patients and staff?
- Recognise staff suffer harm as a result of unsafe systems too: the impact that a patient safety incident has on the patient and their family is a priority. However, the wellbeing of staff involved needs to be recognised and addressed as it can leave staff traumatised, lacking confidence, unable to perform their job, requiring time off, or leaving their profession. Resources to support staff involved in incidents are available through the Improvement Academy's dedicated *Second Victim Support* website [42].
- Feedback: Utility score 3/3. Comments: Need the support processes in place, National Learning Report: Support for staff following patient safety incidents, HSIB 2021, cost of tools?
- Other suggestions: Compassion, civility saves lives, How do you create psychological safety at work? Interview with Amy Edmondson - YouTube,

Psychological Safety and High Performing Teams: Tom Geraghty, Centre For Applied Resilience In Healthcare, Psychology 4 Improvement Q Community

Inclusion and diversity

- Support staff wellbeing and joy in work: The Institute for Healthcare Improvement (IHI) has developed a range of resources, including a *Conversation and Action Guide* [46] to support staff wellbeing and joy in work (JiW) after the COVID-19 pandemic.
- Feedback: Utility score 0/4. Comments: This may not cover enough, JiW and wellbeing are complex and affected by organisational culture, need to create culture where people feel there is equality and equity. How does JiW support diversity? Health and wellbeing conversations are in the People plan
- Reverse mentoring: It can be difficult to understand how it feels to be different members in a team. By partnering with a more junior member of a team from a different diverse background [47], a leader can spend time with them to understand the different perceptions that they have and understand "work as done" rather than "work as imagined".
- Feedback: Utility score 3/3. Comments: need a level of psychological safety before this can happen, need to ensure that the learning impacts on practice and this is not just tokenistic, primary care use "a day in the life of"
- Use first names: In one study 70% of staff found team leaders more approachable if they call them by first name, making it easier for others to speak up about a safety concern, improving patient safety and facilitating quality of care [48]. Dedicate a defined time at the beginning of the day or procedure eg via a safety briefing to introduce all team members [49]. An example of practice that encourages name sharing includes writing your name on your theatre cap [50]
- Feedback: Utility score 3/3. Comments: Useful for patients as badges are not always easy to see, requires a lot of socialisation/role modelling to make it OK to use first names, hard to change norms – not a simple thing to implement, patients/families uncertain of what various job titles mean, ensure safety culture seen in context of other social cultures
- Other suggestions: inequalities of service users is under review in the patient and care race equality framework (PCREF). Need to recognise and respect the input from different members of the team eg carers, create spaces for

conversations to happen about diversity inclusion, privilege and bias, Freedom to speak up.

Improvement and measurement

- Safety culture discussion cards: Thinking and talking about safety culture is vital for us to recognise what we do well, and where we need to improve. The cards describe different safety culture elements and are used to facilitate discussion and identify areas for improvement [53].
- Feedback: Utility score 6/6. Comments: needs to be part of a process for improvement not used in isolation, when are they used/how often? How much will this happen in practice? Maybe have a champion to support the cards and provide improvement ownership? What external help will be provided? Is training needed? So what do you do with the information afterwards? Cards are not directive and can be used in different sectors.
- Safety culture survey: The best safety culture surveys are relatively short, jargon-free, and easy to understand and can be implemented at team, speciality or trust level. A number of tools are available to help you do this [52].
- Feedback: Utility score 4/4. Comments: how do you feedback the survey results? How do you find time and resources to implement? Needs to be linked to leadership and owned at all levels, how are patients/families involved? In primary care at which level would this be targeted? How does the feedback work? Can become stuck in a cycle of surveying without doing any improvement,
- Staff survey safety culture and diversity information: Use data from the national staff survey [54] relating to safety culture questions and identify where these show differences in response by ethnicity or disability. The staff survey culture information is available nationally via the Model Health System (MHS) [55] in the compartment. This information is based on Workforce Race Equality Standard (WRES) [56] and Workforce Disability Equality Standard (WDES) [57] criteria.
- Feedback: Utility score 1/3. Comments: Should encourage use of national survey, does this sit in inequalities space? How does this link to leadership? How will we focus on the right components of safety culture? Is this a blunt tool? Does safety culture include staff safety from V&A? How does this use

data over time for improvement? Surveying needs to be part of a wider approach

- Other suggestions: Safety Attitudes questionnaire has worked well with care homes, do we use MaPSAF as consistent approach? IHI quality improvement essentials toolkit, how do we build safety culture assessment into day to day work? How can patients/carers measure safety culture eg while as inpatients? Are we focussing too much on measurable artefacts? Do we survey people who have been through investigations? How do we ensure these tools are fit for purpose across all sectors of the NHS?

Safety culture measurement

1. The group explored some measurements within the interventions and tools review. In addition, we identified the information end users, key elements of best practice for safety culture measurement, ranked measurements for accessibility and relevance, and reviewed the Quality Toolkit (QT) and Model Health System (MHS) which both support the key elements of measurement and enabled access to users.

2. The end users were identified as: Boards, non-exec directors, clinical leaders, patient safety and quality improvement teams, leadership and organisational development teams, clinicians, commissioners, education leads, HR/workforce, complaints/PALS teams, patient safety specialists, patient safety partners, patients, families, carers, service users, ICS, PCN, local communities, local authorities, GMC, HSIB, NHSE&I, and other regulators such as CQC.

3. Please note that the measurements reported here are not intended to be a comprehensive list, and one of the recommendations is that further guidance on safety culture measurements will be developed. This will include systematic review to identify those that are clear indicators of safety culture and their data source.

Table 3: Key elements of best practice for safety culture measurement

Validated, evidence-based data
Consistency of measures across organisations
Qualitative as well as quantitative
Identifies inequalities
Not used as targets
Believed and valued by staff
Promotes curiosity
Meaningfully recorded over time to show trends eg run charts, SPC
Patient influence and co-design
Easy to access and understand
Sufficient to enable triangulation and meaning
Relevant to different healthcare settings
Ability to drill down to granular ward/team level
Ability to translate to infographic for staff

Timely data accessible to clinicians
Telling stories / lived experience
Enable organisation to focus on metrics they want to improve
Visible to staff and patients/public
All in one place

4. The top five measurements for accessibility and relevance to safety culture were identified in the Model Health System (MHS) as:

- Staff survey - My organisation acts on concerns raised by patients / service users eg q18b
- Staff survey - Raising concerns eg q17b, q17c
- Staff survey - Supportive leadership eg q8a, q8b etc
- Staff survey - Unsafe experiences eg q11b, q12a etc
- Staff survey - Quality of Care eg q7a, q18a etc

Responses to the following patient safety-specific staff survey questions were considered fundamental to continue our understanding of safety culture at organisational level:

- To what extent do you agree or disagree with the following? a) My organisation treats staff who are involved in an error, near miss or incident fairly
- To what extent do you agree or disagree with the following? b) My organisation encourages us to report errors, near misses or incidents
- To what extent do you agree or disagree with the following? c) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.
- To what extent do you agree or disagree with the following? d) We are given feedback about changes made in response to reported errors, near misses and incidents
- Raising concerns about unsafe clinical practice a) If you were concerned about unsafe clinical practice, would you know how to report it?
- Raising concerns about unsafe clinical practice b) I would feel secure raising concerns about unsafe clinical practice.
- Raising concerns about unsafe clinical practice c) I am confident that my organisation would address my concern.

- To what extent do these statements reflect your view of your organisation as a whole? b. My organisation acts on concerns raised by patients / service users.
- I would recommend my organisation as a place to work.
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

Recommendations and outcomes

1. Recommendations and outcomes for the eight themes identified by the group are identified in table 4.

2. NHSEI will establish a safety culture implementation group to provide oversight of the progress of these recommendations. The group will meet every 2-3 months and be made up of members of the Safety culture programme group (SCPG). Terms of reference to be drafted.

Table 4: Recommendations

Theme priorities	Recommendations / Outcomes
1. Definition	• Safety culture definition agreed
2. Team working	• NHS England » The Culture and Leadership programme • NHS England » Civility and respect • Civility Saves Lives • NHS England » Our shared ambition for compassionate, inclusive leadership • A-practical-guide-to-the-art-of-psychological-safety-in-the-real-world-of-health-and-care
3. Improvement and learning	• NHS England » Learn from patient safety events (LFPSE) service • Patient Safety Syllabus – training available online free to all for levels 1 and 2 • NHS England » Patient Safety Incident Response Framework • Action NHSEI: Creating a national primary care patient safety plan • Action NHSEI: safety culture focus groups with CQC Outstanding organisations undertaken and feedback being collated; learning and ideas to be shared.
4. Establishing a safety system	• NHS England » A just culture guide • Patient Safety Syllabus – training available online free to all for levels 1 and 2 • Action NHSEI: MatNeo SIP are piloting the development of a safety system to support safety culture • Action NHSEI: For patient safety specialists, create a safety culture measurement pick and mix guide
5. Practical focus	• NHS England » Patient Safety Specialists

Theme priorities	Recommendations / Outcomes
	• Patient Safety Syllabus • National Guardian's Office: Making Speaking Up Business As Usual • NHS England » Civility and respect • Action NHSEI: For patient safety specialists, create a safety culture measurement pick and mix guide • Action NHSEI: For patient safety specialists, create a safety culture interventions pick and mix guide – to include interventions for different sectors that could include "fun size" options. • Action Safety culture programme group (SCPG): Organisations to offer to pilot safety culture interventions, or provide case studies of safety culture improvements including how to make them work and understanding implementation failures. • Action NHSEI: Publish safety culture guide • Action NHSEI: PSIRF are reviewing with patient safety partners how to involve and support families in the learning process when harm has occurred.
6. Human factors	• Patient Safety Syllabus • Action NHSEI: For patient safety specialists, create a safety culture interventions pick and mix guide
7. Co-production with patients/carers	• NHS England » Framework for involving patients in patient safety • NHS England » Patient Safety Incident Response Framework • Patient Safety Syllabus • National Guardian's Office: Making Speaking Up Business As Usual
8. Appreciating complexity and layers	• Action NHSEI: Creating a national primary care patient safety plan • NHSEI MatNeo SIP are piloting the development of a safety system to support safety culture

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