@ptsafetyNHS

NHS England

Patient safety culture

For: Patient safety Manager Network

July 2023

Presented by:

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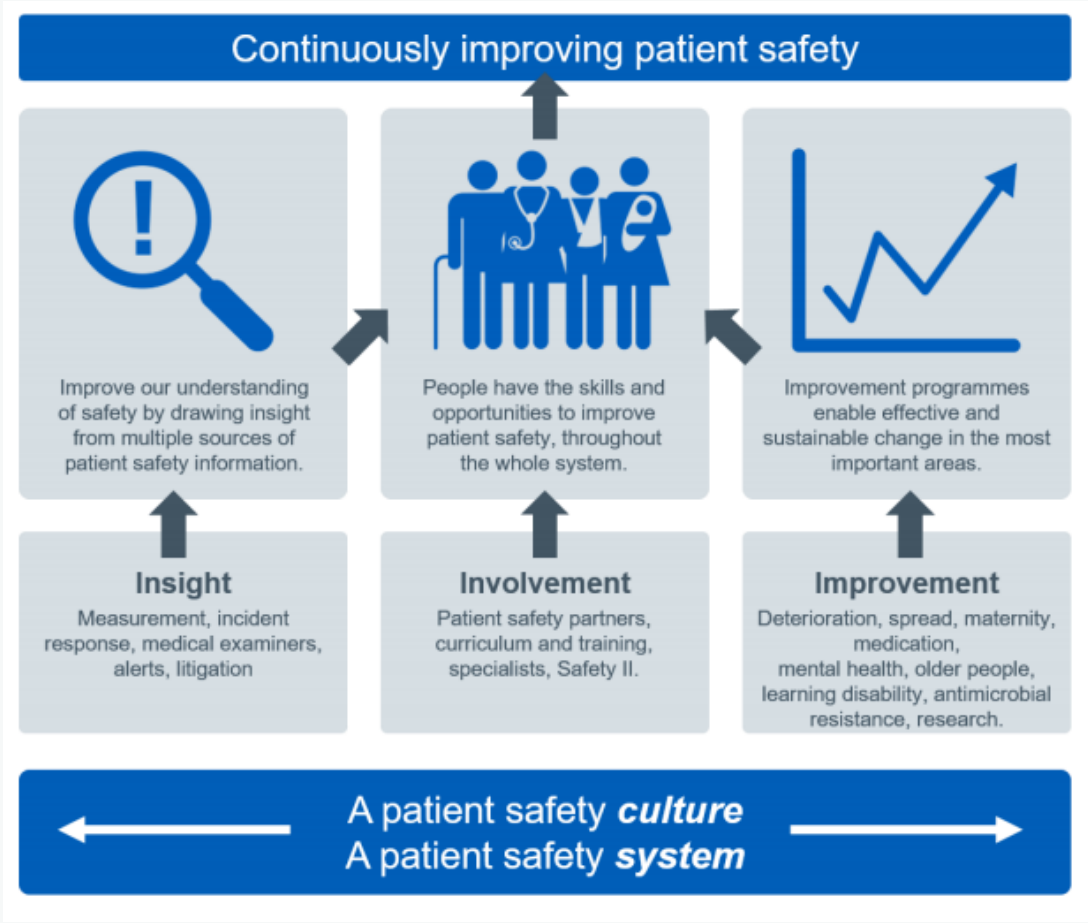
The NHS Patient Safety Strategy (2019)

The NHS Patient Safety Strategy provides a structure for all our patient safety work:

- **A patient safety culture** – encouraging engaged, visible leadership promoting openness, just culture and continuous improvement, valuing diversity and equality.
- **Patient safety systems** – governance, accountability, supporting whole systemic and systematic improvement, including primary care, intelligent use of digital.
- **Insight** – a whole organisation commitment to identifying risks, reporting incidents, understanding what contributes to safety, identifying how we normally keep our patients safe
- **Involvement** – a focus on people, giving them the skills and support they need, fundamentally involving patients and the public, recognising the need for specific expertise
- **Improvement** – identification and implementation of improvement priorities using quality improvement science to continuously reduce risks to patients.

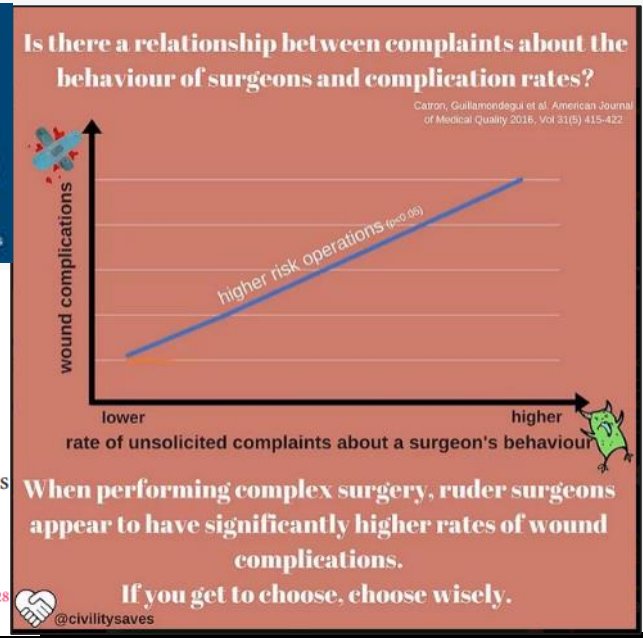


Evidence that a good safety culture reduces patient harm…

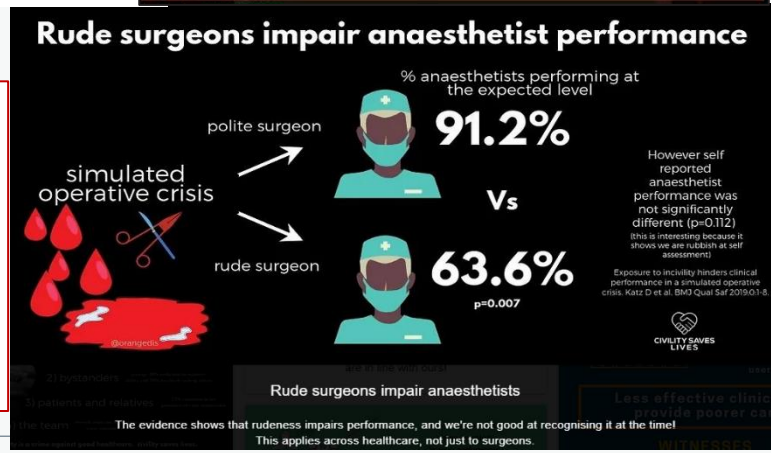
- Leadership and leadership development health care (2015) Positive effects of transformational leadership have also been demonstrated in relation to work-life balance, staff well-being, positive nursing outcomes, patient safety, openness about errors, and patient and staff satisfaction (Munir, Nielsen, Garde, Albertsen & Carneiro, 2012; Apekey, McSorley, Tilling & Siriwardena, 2011; Cummings et al., 2008; McFadden, Henagan, & Gowen, 2009; Kvist, Mantynen, Turunen, Partanen, Miettinen, Wolf & Vehvilaninen-Julkunen, 2013; Wong, Cummings & 11 Ducharme, 2013).
- If it's about NHS culture, it's about leadership (2016) Research shows that organisations with cultures that deliver high-quality, continually improving and compassionate care are those with good leadership.
- The Freedom to Speak up Report (2015) Speaking up is essential in any sector where safety is an issue. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish. There needs to be a more consistent approach across the NHS, and a coordinated drive to create the right culture.
- Does Improving Safety Culture Affect Patient Outcomes (2011) A small number of studies have found a relationship between safety culture or climate and hospital morbidity, adverse events and readmission rates. But other studies have found that safety culture has no impact on patient outcomes. There is more evidence that improving safety culture impacts on staff safety behaviours and injury rates among staff.
- QI Podcasts - Oxford Healthcare Improvement (2021)
- Civility Saves Lives
- Caring_to_change_Kings_Fund_(2017)

Readmission rates

For instance, researchers in the USA examined the relationship between hospital patient safety climate and rates of rehospitalisation within 30 days of discharge. Survey data from 36,375 staff from 67 hospitals were compared with risk standardised hospital readmission rates. Poorer safety climate was associated with higher readmission rates for heart attacks and heart failure. Frontline staff perceptions of safety climate were associated with readmission rates but senior management perceptions were not.[28]



Other researchers in the USA assessed the relationship between hospital safety climate and patient safety performance indicators. Data from 91 hospitals were analysed. Hospitals with better safety climate overall had fewer patient safety incidents. Interestingly, frontline staff perceptions of better safety climate predicted lower risk of experiencing patient safety incidents, but senior manager perceptions did not.[38]



NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide [illegible] before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If **No to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If **Yes to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

Patient safety culture

Definition:

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:

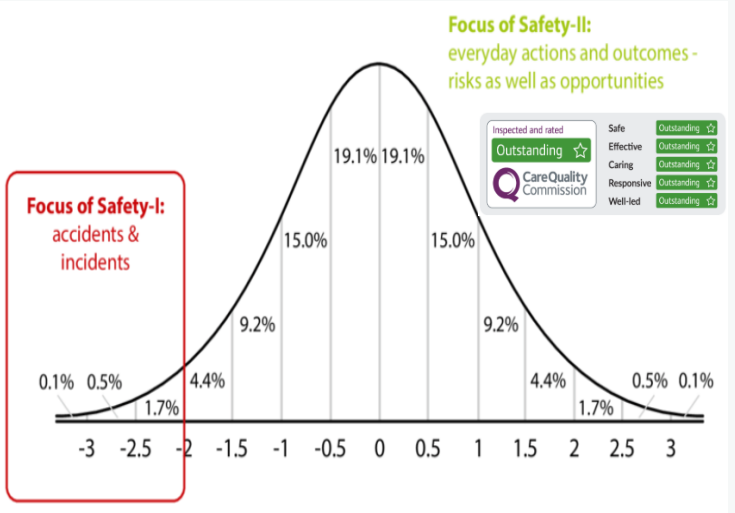
- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all

Fundamental to ensuring safety is the development of a strong safety culture:

- Staff must be supported and encouraged to raise concerns
- A '[Just culture]' must be in place where staff don't feel they'll be blamed or disciplined for errors
- Staff should feel psychologically safe in their workplace, and have access to support

Safety culture: Learning from best practice

- Safety culture: learning from best practice published November 2022
- Based on focus groups with CQC-rated outstanding or good organisations: acute, specialist, community, mental health, and primary care
- Using a safety II approach – focussing on what goes right, insights, good practice and case studies
- Context is everything and improving safety culture is not just about **what** interventions happen, it is also about **how** these interventions happen
- Six themes:
  - Leadership
  - Continuous learning and improvement
  - Measurement and systems
  - Teamwork and communication
  - Psychological safety
  - Inclusion, diversity and narrowing healthcare inequalities



“Supporting staff after patient safety incidents improves safety in the NHS”

Nursing Times (2021)

NHS Staff survey 2022

Raising concerns sub-score: 2022: 6.4 (2021: 6.5)

Speaking up about concerns

The following percentage of staff said they...

61.5% ...feel **safe to speak up about anything that concerns them** in their organisation (q23e) (2021: 62.1%, 2020: 65.7%)

48.7% ...were **confident that their organisation would address their concern** (q23f) (2021: 49.8%)

Concerns about clinical safety

The following percentage of staff said they...

71.9% ...would **feel secure raising concerns about unsafe clinical practice** (q19a) (2021: 75.0%, 2020: 72.7%, 2019: 71.9%, 2018: 70.9%)

56.7% ...were **confident that their organisation would address their concern** (q19b) (2021: 59.5%, 2020: 60.5%, 2019: 59.9%, 2018: 58.6%)

Q19a - **I would feel secure raising concerns about unsafe clinical practice**. The national average has dropped from 75.0% to just 71.9% with a corresponding deterioration seen across all sectors;

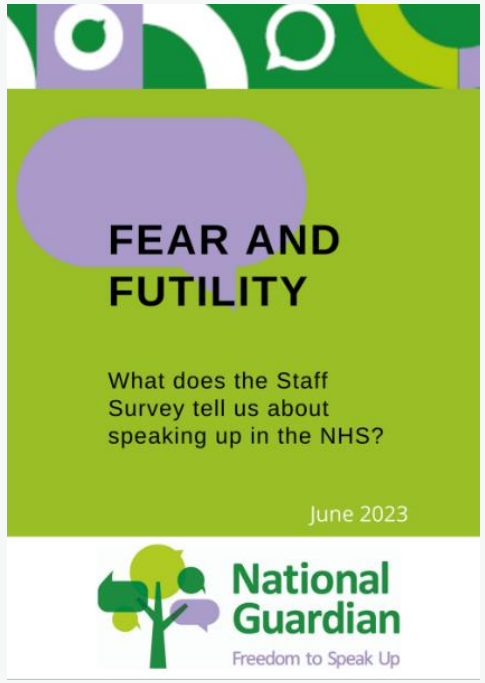
Q23e – **I feel safe to speak up about anything that concerns me in this organisation.** The deterioration in results between 2020 and 2021 from 65.7% to 62.1% continued with a further drop to 61.5% in the 2022 survey results;

Q19b **– I am confident that my organisation would address my concern**. The national average has dropped from 59.5% to 56.7% with a corresponding deterioration seen across all sectors;

Q23f – I**f I spoke up about something that concerned me, I am confident my organisation would address my concern.** The response to this question, new in 2021, has also seen a deterioration nationally from 59.5% to 56.7% with an enormous disparity between the best and worst trusts.

Speaking up (FTSU)

- Freedom to Speak Up is about speaking up about anything that gets in the way of doing a great job.
- There are over 800 Freedom to Speak Up Guardians across the NHS who support workers to speak up when they feel that they are unable to in other ways
- 20,362 cases raised (1 April 2021 to 31 March 2022)



Key Findings

- The Freedom to Speak Up sub-score declined from 6.5 in 2021 to 6.4 in this year's NHS Staff Survey. This equates to a declining perception of over 9,000 workers.
- There was a marked fall for raising concerns relating to clinical practice
- Bank staff survey results were in line with the core survey results
- By sector, ambulance trusts continue to score least
- The Freedom to Speak Up sub-score positively correlates with Care Quality Commission ratings.
- Medical trainees' confidence in speaking up has deteriorated markedly
- Results for other medical/dental staff groups, for example consultants, are also deteriorating faster than other occupational groups
- The gap between the better and worse Trusts is widening

NHS England

Improving Patient Safety Culture

A practical guide

In association with

The AHSN Network

[NHS England » Improving patient safety culture – a practical guide (2023)]

How does our system view shape our perspective of safety culture?

- Views of ‘the system’
  - Mechanical, ‘cogs in a machine’
  - More organic ‘living ecosystem’

How does culture shift?

Seeing culture as a dynamic social construct focuses our attention on to our interactions with those in our team and other teams. This emphasises the importance of how we create the space to optimise the relational aspects of the work. In structured parts of work we have traditionally focused on, and measured, process metrics e.g. that teams are meeting, who is there and how long it takes, and not considered the quality of how we work together. It is often only when outcomes are poor or relationships break down that we try to understand how a team is working together.

a dynamic social construct

What we have learnt

- The way that we talk about safety culture matters

- Moving from ‘the intervention is the solution’ to ‘how it is done’:
  - How the social structures support the intervention itself
  - How are we enacting our values in our work

Definition:
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Safety culture: What? How?

The way we focus on safety culture matters

- We often separate out '**what**' work we do from '**how**' we work
- Instead consider the '**what**' and the '**how**' as two intertwined threads
- Emphasises the importance of how we create the space to optimise the relational aspects of the work
- Consider the quality of how we work together:
  - Create space and time
  - What we talk about
  - How we talk and work together
  - Embodiment of positive values
- This guide is not a recipe, rather a menu of ingredients and a toolbox to help you create a tailored strategy

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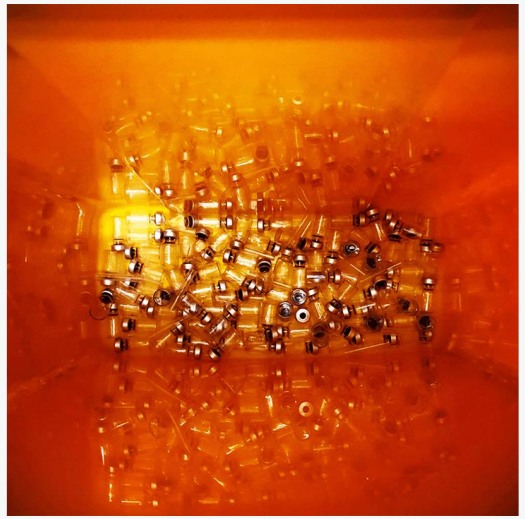
Individuals and team flourishing	Brilliant, safe care and experience
Leadership	Continuous learning and improvement
Teamwork	Safety I & Safety II
Communication	Learning from Excellence
Just Culture	National Patient Safety Improvement Programmes
Psychological safety	Appreciative inquiry
Promoting diversity and inclusive behaviours	Patient centred collaboration
Staff well being	
Civility	
Organisational Development	



Teamwork and communication

TOP TIPS:

Working together as a team

Adapted from *Extreme Teaming: How to Deliver Integrated Care*

Aim high: set a clear, ambitious, compelling, meaningful vision which inspires people by focusing on the things that matter to the team

Team up: value the diversity of the team as this will lead to a greater ability to achieve breakthroughs

Fail well: identify opportunities for intelligent failures that provide information on how to improve approaches and systems next time round

Learn fast: maximise learning from mistakes – apply focus, discipline and structure when reviewing them.

3

Initiate safety huddles

Use resources including the "Yorkshire Safety Huddles Manual" to initiate safety huddles, starting with a single team.

Space: create a time in the day when safety huddles can occur.

What: Any aspect that affects safety can be discussed by understand the importance of the conversation in developing the social relationships between team members.

How: Starting with everyone introducing themselves (even if we think we know everyone) flattens the social hierarchy and makes it more likely that everyone will feel able to speak later and contribute to the duffle and allow all forms of expertise to be valued and heard.

Read about the Innovation Agency's Coaching for Culture programme, which included accredited coaching training for team leaders, use of a team culture diagnostic, and use of practical QI skills to support the development of safe, high-quality, and compassionate services in the North West.

What: In the discussion ask what the people's experiences have been when things have gone wrong and how they felt and how they thought it was for the patient and families. There is a need for a shift in the language that we use and the approach to incidents that focus on the learning – what happened not who was involved.

How: Consider how to involve everyone in the discussion so that all the perspectives are heard and the process supports the principles of openness, honesty and transparency.

"A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability."

Being Fair, NHS Resolution

3

Use the NHS Just Culture Guide:

This is a way to ensure that everyone is treated fairly in the event of an incident of harm. The NHS Just Culture Guide is a tool to support individuals to treat staff fairly, consistently and constructively if they have been involved in a patient safety incident and to help to prevent unconscious biases.

CASE STUDY:

Supporting team health: A simple framework and a tale of three teams

Jo Davidson, Associate Director Organisational Effectiveness and Learning and
Melissa Holt, Strategic Organisational Effectiveness Lead

Overview

More than two years responding to COVID has reinforced the significance that great teamwork has on both staff wellbeing and the safety, quality and experience of care they provide. NHS organisations are full of people caring for others but what happens when those teams, become stuck in conflict, toxicity or resistance to change? These sorts of comments are not common to any one organisation, the experiences by these teams are all to common across the health service.

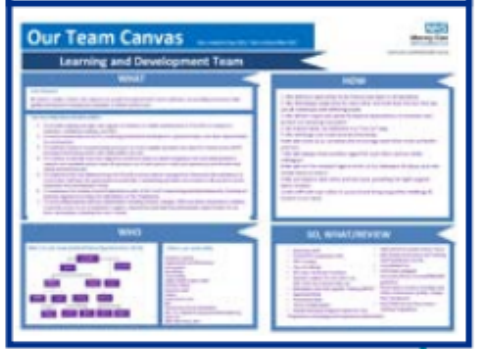
This piece tells the story of three such teams, brought back to health with the use of a simple tool - The Mersey Care "Team Canvas", and how that tool has been used to facilitate team health and culture across the Trust. It includes how it has been designed and implemented to integrate with our clinical assessment, improvement and accreditation processes which enables us to track and measure improvement and demonstrate the impact not just to our colleagues, but importantly to our patients.

This excerpt provides detail in relation to just one of the OD interventions that have been designed and developed to support a Restorative, Just and Learning Culture at Mersey Care NHSFT, all of which are described within the recent publication of 'Restorative, Just Culture in Practice'.

"Managers don't trust us, we're closest to the patients and yet when we put ideas forward, no one listens, we're the bottom of the pile" **Team A**

"In this team I've lost my confidence and any sense of feeling valuable or valued" **Team B**

"Changes are not discussed. They are dictated, regimented and we are told - not asked" **Team C**



Psychological safety

Stage 1 Inclusion Safety: Team members, whatever their age, sexuality, ethnicity or race, feel that they are included and valued and that they are appreciated by the team.

Stage 2 Learner Safety: Team members are able to admit that they don't know things and are able to ask questions and start to try new things.

Stage 3 Contributor Safety: Team members are able to voice their own ideas without fear of being ridiculed or embarrassed.

Stage 4 Challenger Safety: Team members are able to question the thoughts of others in the team including those with power.

Psychological Safety Survey

1. If you make a mistake in this team, it is often held against you.
2. Members of this team are able to bring up problems and tough issues.
3. People on this team sometimes reject others for being different.
4. It is safe to take a risk on this team.
5. It is difficult to ask other members of this team for help.
6. No one on this team would deliberately act in a way that undermines my efforts.
7. Working with members of this team, my unique skills and talents are valued and utililsed.

Amy Edmondson. The Fearless Organization. Wiley, 2019

Promoting diversity and inclusive behaviours

- Diverse teams hunt the good stuff – the things that unite and energise you and which give you shared common purpose.
- Diversity of thought is paramount.
- Encourage patients, carers and families in all their diversity to be at the centre of your plans and involved in co-creating them.

Three change ideas to try:

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 to support staff wellbeing and joy in work after the COVID-19 pandemic.

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, 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"'.

Always events
Implement the Always Event methodology – aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the system – as a means of consistently putting patients at the heart of the care provided.

'Paul and Flo'

7. Civility

Civility is essential for individuals and teams to fulfil their potential and "civil work environments matter because they reduce errors, reduce stress and foster excellence." It "creates that sense of safety and is a key ingredient of great teams."

The Civility Saves Lives campaign promotes the importance of respect, professional courtesy and valuing each other. The campaign aims to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can understand the impact of our behaviours. Patients, carers and families notice incivility between team members, which can lead to increased feelings of fear and vulnerability, and a poorer patient experience. The campaign includes examples of how teams have sought to make patients active participants in fostering a positive safety culture.

There is also a NHSE Civility and Respect Toolkit with a number of resources within it to support teams.

Space/time: Add the topic of civility to a team meeting.

What: Use the infographics to start a discussion or watch a video. Discuss what team members experiences of civility and incivility are and how they have felt when these have occurred.

How: Discuss what clear standards and expectations the team have and role model respect and care for others to enable meaningful and respectful connection and participation.

'Mother Obe'

Next steps

Acknowledgements:
National Patient Safety Improvement Programme, National patient safety team with Patient safety partners, Safety culture programme group, Academic Health Science Networks (AHSNs), Our NHS at 75: Through the lens of NHS staff and volunteers

Thank you

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Kindness in healthcare:
https://kindnessinhealthcare.world/