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Safety culture: learning from best practice

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Safety culture context within the NHS patient safety strategy

1. We define a positive safety culture as 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:

   i) Continuous learning and improvement of safety risks

   ii) Supportive, psychologically safe teamwork

   iii) Enabling and empowering speaking up by all

2. Trying to understand, measure and improve safety culture can appear to be nebulous goal. However, it is one of the two key foundations of the NHS Patient Safety Strategy, so in 2019, we set out to understand more about what makes an organisation outstanding for patient safety culture.

3. Only a handful of trusts are rated outstanding by the CQC and previous analysis by NHS Improvement in 2018 showed that on average most trusts are rated lower for the Safe domain. We recognise that the CQC rating is only one measure of safety and safety culture; however, in order to have a simple, consistent and recognisable approach, we chose to ask organisations that were CQC-rated Outstanding/Good for the safe domain to participate in this review.

4. Using a Safety-II inspired approach to learn from every day work (Hollnagel et al., (2015) From Safety-I to Safety-II: A White Paper), we identified organisations that were CQC rated as good/outstanding in Safe. In 2019 and 2021 we undertook a series of focus groups with Executive and quality leads across acute, specialist, mental health, community, and primary care organisations to understand what their safety culture looked and felt like and what we could learn.

5. We understand that organisations are at different stages of their safety culture development and that one size does not fit all. The ideas shared here can be explored via a variety of approaches such as coaching. Within safety culture,

context is everything and improving safety culture is not just about **what** interventions happen, it is also about **how** these interventions happen ie how change is implemented[1].

6. Here we share the insights from these discussions and some ideas of good practice that may be helpful relating to the language, tools, and interventions that these organisations have used to help improve their patient safety culture. It should be noted that these ideas have not been formally reviewed and this report is not proposing formal recommendations or requirements. It is intended to inspire and support local safety culture improvement activity and to inform further national work on safety culture improvement.

7. Six themes were identified from the discussions and the good practice ideas identified are summarised in the boxes below, alongside a brief introduction.

[1] Context for Successful Quality Improvement, Health Foundation (2015)

1. Leadership

1. Leadership was identified as a fundamental part of safety culture within our discussions. The King's Fund's blog on NHS leadership and culture, states that: "*Collaborative, inclusive and compassionate leadership is essential to deliver the highest quality care for patients and tackle deep-seated cultural issues in the NHS, including unacceptable levels of work-related stress, bullying and discrimination*." Thus, leadership is a key influencer of safety culture and was certainly mentioned within these safety culture discussions.

2. Leaders should have values and behaviours that inspire understanding and trust, build inclusion and reduce inequalities as described in "Our shared ambition for compassionate, inclusive leadership" (NHSEI, 2021). This is further supported in: "What is compassionate leadership? (The King's Fund, 2022), which highlights the evidence that compassionate leadership ultimately results in high-quality care.

3. The Leadership for a collaborative and inclusive future report (2022) noted "*the very real difference that first-rate leadership can make in health and social care, with many outstanding examples contributing directly to better service*". This clearly aligns with the Next steps for integrating primary care: Fuller Stocktake report (2022) that identified that "*what truly drives change is a leadership culture that promotes an enabling and psychologically safe environment, and the capacity, time and skills for people to learn and experiment*."

Leadership good practice ideas from trusts rated ‘good’ or ‘outstanding’ in Safe care by CQC

<table>
<tr>
<td>Vision
Create a clear relevant vision, underpinned by key values, compassion, creativity, and community which aligns with Long term plan and People plan
Focus on one safety priority for the organisation’s quality account to drive improvements and clearly communicate the vision</td>
<td>Recruitment
Start emphasising at the interview stage that recognising, and reporting incidents leads to learning
Use values-based recruitment to ensure a good fit with the organisation.
Create a senior patient safety role (eg patient safety specialist), which could be at director level.
Appoint experienced clinicians into senior corporate roles so they can directly influence the operational teams.
Invest in leaders for patient safety alongside those for quality improvement
Focus on quality, and specifically patient safety, makes it easier to retain good staff including clinicians</td>
</tr>
<tr>
<td>Behaviours
Give people permission to have time for safety when it gets busy
Undertake monthly Non-executive director walkarounds that are conversations, rather than tick box exercises
Lead by example and embed culture in practice such as encouraging people to raise no/low harm incidents</td>
<td>Governance
Make the safety strategy a key part of the board agenda
Ensure the safety strategy includes Organisational development and just culture
Encompass quality improvement, clinical effectiveness, patient safety, patient experience, and complaints in one executive director portfolio</td>
</tr>
</table>

Behaviours	Governance
• Involve everyone in patient safety from the maintenance team to senior clinicians • Show commitment and invest time by senior leaders, especially the CEO, • Leaders need and seek peer support, and value fresh eyes from colleagues in other organisations. • Role-model, 'living' values and calling out poor behaviour are important, from the CEO onwards.	• Place carers and Governors on the patient safety committee. • Maintain leadership professionalisation through initial and ongoing training

2. Continuous learning and improvement

1. As James Reason stated: "*Safety is a continually emerging property of a complex system*."[2] Thus continuous learning leads to continuous improvements in patient safety and is very much supported by the science of improvement[3].

2. Within the focus groups, discussions centred on firmly linking safety and quality improvement into a cohesive system where co-production was highlighted as best practice.

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[2] Reason, J. T. (1997). Managing the risks of organizational accidents. Aldershot, UK: Ashgate Publishing Limited.
[3] science of improvement Institute for Healthcare Improvement website, accessed 13/06/22

Continuous learning and improvement good practice ideas from trusts rated 'good' or 'outstanding' in Safe care by CQC

Quality improvement	Improvement actions
• Focus safety activity via a dedicated central safety team. • Set up a research and quality improvement academy including projects on safety and improvement. • Ensure quality improvement teams support and enable frontline clinicians, who own and lead the improvement work themselves. • View improvement of safety and wider quality as a journey with an identifiable starting point. • Understand that an improvement journey is hard, with barriers including funding, staffing levels and service pressures. • Recognise and share positive practice and achievements as a common activity. • Make an unflinching commitment to ensure progress and unity, founded on an "emotional connection" to patient safety at board-level. This includes the development of confidence and belief amongst frontline staff – which can be grown via focused, evidence-based quality improvement programmes.	• Shift the focus from blame to learning by reviewing the actions from previous incident investigations and identifying effective learning and actions and use these as future examples of good practice • Push to apply quality improvement methodology to action planning (eg using the PSIRF safety action development guide) across all governance: incidents, complaints, audits etc • Make action plans smaller – eg 5 things maximum and also identify the impact that these actions will make. • Consider the use of the SWARM approach (Swarm: a quick and efficient response to patient safety incidents | Nursing Times) for incident response (note further information on incident response is available as part of the new Patient Safety Incident Response Framework) • Prompt feedback after incidents and the actions that are taken • Create a culture of pursuing ideas and making changes • Understand that there is no overall 'end point'. Constant honesty, curiosity and

	energy are necessary to continue driving continuous improvement.
Co-production • Undertake incremental changes, via co-production • Use patient feedback to generate improvement priorities. • Create direct escalation mechanisms for patients or relatives to raise concerns with doctors, outreach teams, or on-call nurses	**Priority setting for improvements** • Ensure alignment of quality improvement with patient safety systems and strategy • Enable priority-setting to incorporate both central and departmental priorities, promoting frontline ownership to ensure relevance.

3. Measurement and systems

1. It is not easy to measure safety culture, as many changes beyond those you are introducing may indirectly contribute to improvements in culture. However, an initial assessment can enable you to capture a baseline understanding of your safety culture, and where collectively you can prioritise your efforts. Being able to measure your safety culture will help to identify changes that work and to celebrate success.

Measurement and system good practice ideas from trusts rated 'good' or 'outstanding' in Safe care by CQC

Measurement	Systems
• Use staff survey Question 16 (ie My organisation treats staff who are involved in an error, near miss or incident fairly) to understand whether staff feel valued and able to speak up • Use data to reveal trends, use these to trigger deep conversations which can lead to change. • Use staff measures, such as staff retention and feedback • Use patient-assessed measures such as compassionate care and pain control as key revealing metrics. • Look at 'soft intelligence' or the 'feel' of a clinical space eg The Fifteen Steps Challenge (2017), as well as surveys such as GMC, staff and area-specific culture surveys.	• Aim to implement well-designed patient safety information systems to increase automatic data capture • Build engagement tools to share patient safety improvement information with wards and community teams • Provide data / information that is more meaningful to teams and individuals • Recruit a business intelligence analyst in patient safety to link incidents, learning from deaths and complaints to identify patient voices that can be used as examples and stories. • Ensure that access to useful, high quality data is proactive and addresses areas of outlying concern • Focus on work as done and observed, rather than work as imagined.

4. Teamwork and communication

1. Teamworking is fundamental to delivering safe, high quality care, whether that is in the labour ward, ICU, an ambulance or in general practice. Making teams function effectively is a complex task where collaboration and good communication are fundamental. Communication should be open, respectful, honest, two-way, and inclusive across disciplines and professional groups.

2. Professor Amy Edmondson has studied what “good” looks like when people come together to work as a team, and calls this “teaming”. She describes a four part approach to increase the chances of success in Extreme Teaming (2019). The Kings Fund published “How to build effective teams in general practice” (2020) that brings together insights from research and policy.

Teamwork and communication good practice ideas from trusts rated ‘good’ or ‘outstanding’ in Safe care by CQC

Messaging	**Teaming**
• Use storytelling which has greater impact on staff, include patient and staff stories by video, virtual or face to face • Actively involve staff in safety conversations • Present an annual thematic review in grand round of all incidents, learning from deaths (LfD) data and complaints. • Generate one-page learning notes, to share the impact and learning. • Use the opportunities of emotional connection for people with patient safety	• Use a What matters to you?(WMTY) philosophy and work with clinicians and communities and staff group. • Promote team building through the use of protected team-time, and expectations that senior leaders should build strong relationships with frontline staff. • Pay attention to skill mix, with creative deployment of experienced staff to support colleagues.

Networking	Language
• Establish clear links across pathways, with focus on transitions of care in the whole system ie ICS • Set-up twice yearly organisation-wide safety meetings, with all (clinical and non-clinical) staff invited and encouraged to attend • Have regular, inclusive engagement and community-building safety huddles (in person/virtual)	• Use patient safety incident response-style language to move from Serious incident investigation / significant events to learning response, learning events, safety studies etc • Use Easy as 123 SEE = Safety Experience Effectiveness. • Tailor messages to articulate and emphasise the relevance to different staff groups.

5. Psychological safety

1. Psychological safety is defined as "*a shared belief held by members of a team that the team is safe for interpersonal risk-taking*."[4] It is about being open, willing to admit mistakes and feeling supported to speak up. Psychological safety is not just being nice to people, nor is it protecting people by wrapping them up in cotton wool; it is about creating an environment of rewarded vulnerability. The premise of psychological safety is not measured by how warm and fuzzy people feel, but by how bold and brave they are at pushing the margins of the system.

2. Unfortunately, in healthcare there can be a culture of blame and fear, from the mistaken belief that patient safety is about individual effort, rather than the interactions of usual human behaviour and systems, both of which can easily fail. Challenges to enabling psychological safety were discussed in the focus groups and some approaches identified.

[4] Managing the risk of learning: Psychological safety in work teams (2002)

Psychological safety good practice ideas from trusts rated 'good' or 'outstanding' in Safe care by CQC

Civility	Appreciation
• Talk about key cultural issues constantly such as psychological safety, civility, diversity of thinking and humility. • Make personal connections and get to know staff as individuals. • Create a leadership promise and behaviour framework that staff can sign up to • Leaders at all levels build relationships, listen, and respond to feedback and tailor support to suit real, frontline needs. • Demonstrate constant honesty; it is a foundational value	• Show that you value staff by ensuring that they feel safe and supported, particularly when things go wrong. • Appreciate staff potential, and grant freedom and permission to innovate. • Create an open, trusting culture where staff are able to speak up and highlight problems. Champion the importance of openness and honesty. • Focus on training in human factors and identifying coaches to support safety strategy • Enable autonomy, belonging and contribution to changes via ideas such as ward accreditation programmes.

6. Inclusion, diversity and narrowing healthcare inequalities

1. The first principle in the NHS Constitution for England (2015) is that the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. We need to ensure that the service is designed to improve, prevent, diagnose, and treat both physical and mental health problems with equal regard. We have a duty to each and every individual that the NHS serves, and we must respect their human rights. At the same time, the NHS has a wider social duty to promote equality through the services it provides and to pay particular attention to

groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. During the COVID-19 pandemic healthcare inequalities have become more apparent and significant work is now underway across all aspects of healthcare to narrow inequalities for both patients and staff.

3. The 2022 NHS Race and Health Observatory's Ethnic Inequalities in Healthcare report highlights areas that require attention including: mental health, maternal and neonatal health, digital inclusion, genomics and precision medicine, and the health and care workforce. The report also provides overwhelming evidence of ethnic health inequality through the lens of racism and expects leaders to hold themselves and their organisations to account to implement change. For example, studies found that Black children were 10 times more likely to be referred to CAMHS (Child and Adolescent Mental Health Service) via social services (rather than through the GP), relative to White British children.

4. One of the report's recommendations is to: "*Work to build trust with ethnic minority groups and key voluntary, community and social enterprise (VCSE) organisations*". This level of trust and interaction can be enhanced by co-production with patients, families and carers and is well demonstrated in case study 3, from Solent NHS Trust.

Inequalities good practice ideas from trusts rated 'good' or 'outstanding' in Safe care by CQC

Co-production	Empowerment
• Highlight the expectation for services and teams to include co-production with service users/carers as part of all projects • Support an active patient participation group • Engage with Healthwatch, who have helped general practices identify and work with local patients • Focus on patient populations' needs, rather than on external assessments	• Work on what is Strong, not what is Wrong • Work alongside communities and groups who face healthcare inequalities to enable relationships and empower partnership engagement. • Enable carers to contribute as 'care partners' for patients

We are grateful to the following organisations for their time and contributions to this review:

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- Harleston Medical Practice
- Herefordshire and Worcestershire Health and Care NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Kingston Hospital NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Marden Medical Practice
- Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- Royal Marsden NHS Foundation Trust
- Royal Papworth Hospital NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Solent NHS Trust
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Stanmore House Surgery
- West Kent ICP
- Western Sussex Hospitals NHS Foundation Trust

Case studies

All case studies are available for download via: Learning from best practice - NHS Patient Safety - FutureNHS Collaboration Platform

Case study 1: Leadership Promise and Behaviour framework dictionary, Norfolk Community Health and Care NHS Trust

Norfolk Community Health and Care worked with their staff to develop their Behaviour Framework in 2019 to improve the quality of people's lives in their homes and community through the best in integrated health and social care. They identified a ten-point leadership promise that each leader signs up to, committing to deliver the best patient care.

View the Leadership Promise and Behaviour Framework Dictionary on FutureNHS.

Case study 2: Safety Strategy and SCARF, Central and North West London NHS Foundation Trust

Central and North West London NHS Foundation Trust created their 2021-2024 safety strategy focussed on Improving Safety, Reducing Harm. Their strategy provides a "call to action" for all staff to reflect on what is important in their particular service to improve safety for their patients, and safety for their staff. This includes staff signing up to pledge their commitment to a safety initiative.

Alongside this, they have set in place the SC&RF approach: Safe, Compassionate & Reflective, Fair. It is about their patients and staff and has been introduced because staff have said that change is needed to develop a climate of openness and psychological safety.

View the Central and North West London NHS Foundation Trust Safety Strategy and SCARF on FutureNHS.

Case study 3: Alongside Communities, Solent NHS Trust

Alongside Communities: The Solent Approach to Engagement and Inclusion was developed in 2020. This was developed in partnership with local people to improve health and reduce inequalities in their local community.

View the Solent NHS Trust 'Alongside communities' document on FutureNHS.

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