Insights from a Just Culture in practice focus group

To support organisations to achieve a just culture, we sought insights on what should be considered from clinical leaders at trusts across all sectors whose staff say they are treated fairly. Using the 2017 NHS Staff Survey we identified organisations from each sector with the highest percentage of staff that responded positively to the question “My organisation treats staff who are involved in an error, near miss or incident fairly”.

Here is what they said.

1. Focus more on behaviour and less on procedures to change culture

The group discussed what action helps promote a safety culture.

Participants felt that it is the style of the response to incidents and the personal behaviour of leaders in this that makes the difference to promoting fairness, rather than the exact governance arrangements for the response. On paper the policies, committees and panels for responding to incidents, Serious Incidents and mortality review look very similar across all trusts.

“Behaviours are easier to understand than ‘culture”,” said one participant. “People will react to what they see execs do, not what they see them write in newsletters and policies. Same is true for managers. You can visibly see when you are in a well-led ward.”

Trusts have taken measures to reduce the anxiety of staff involved in an incident. For example, one does not typically require clinicians to come to and give a statement at Serious Incident panels. They do most of the work from the clinical notes and treat it as a peer review process.

Others are very attentive to language used when investigating an incident. They were not setting up “investigations” but “conversations”, not “taking a statement” but “getting their views”.

The participants seemed to agree that while the ability to scrutinise accounts provided by staff to get to the bottom of what happened remained important, there was a skill to doing this in a non-threatening, non-personal way. Some trusts ask their Serious Incident panels to

look at themes and clusters of multiple incidents together to help lift the focus on any individual incident. Their Serious Incident panels have also tended to evolve beyond looking at Serious Incidents only because staff have found the panel's peer advice so helpful that they wanted to be similarly advised on other safety issues.

Transparency is seen an ally, not a threat, to openness. One trust involves executive directors in their Serious Incident panels and invites regulators and commissioners to attend. Panels are open to anyone to join. Regulators and commissioners are invited to join, which they sometimes do, and the trust believes this encourages a non-defensive response that all staff pick up on.

Some trusts have relatively traditional models of allocating responsibility for investigation to a range of staff, and some dedicated investigations panels whose members do this full time. Interestingly, many felt that investigation skills training, including root cause analysis training, can only take their investigators so far; a key determinant of whether someone can carry out or support good quality and fair investigations is has more to do with the personalities and 'soft skills' of the people involved.

One participant stressed that the trust's leaders need to understand what a good quality investigation looks like, and constructively challenge and encourage investigators to go deeper. For example, if a report comes back stating that an incident was down to 'human error', they ask them to look at how the potential for error could be designed out. But the style in which these questions are asked is thought to be critical: "the ability to scrutinise without intimidating is incredibly important".

Executives need to show humility and a willingness to learn: "[the SI panel] is a huge learning process, and I continue to learn every week".

A focus on positive action is key to how staff respond to the experience, or as one participant put it whether they "come away feeling awful or come away feeling something positive is going to happen from all this".

One participant emphasised that a just culture can't simply be delivered through how you respond to incidents, as the need for justice and fairness needs to permeate everything you do, whether that is recruitment, access to training or even the Christmas off-duty rota. They captured this by saying: "There is no such thing as 'just culture' in isolation. It's really just 'your culture'." The belief was that the mutual trust built up in more everyday issues was an important basis for trust when staff were involved in an incident.

2. Support patients and families affected by patient safety incidents to make the experience better for everyone

All the trusts present were very clear that patients and their families require support and deserve to know what happened when they were harmed. Many participants said that engaging with families helps promote safety.

One trust selects patients and families at random to attend board meetings and tell their stories – both good and bad. It believes this shows its leaders want to listen and respond to concerns publicly and not leave those difficult conversations to frontline staff. Random selection of patients and families reduces the risk leaders appear to control the messages they want to hear and helps them hear 'quiet voices' as well as those of people who come forward with compliments or complaints. All participants said that actively seeking views, rather than waiting for them to present, was an important aspect of their trust's culture.

Most participants had experienced patients or families who want someone blamed following an incident, including threats to go to press or refer staff to their professional regulators unless someone is 'sacked' or 'disciplined'. They emphasised that although rare, it would happen from time to time, and thought it was important to be open about the leadership challenge of this. On the one hand they had to ensure empathy and understanding as the patient or family had every right to feel that way, but also had to ensure staff were treated fairly and the distress staff and their support needs were also considered.

Many participants felt that it is important for staff and families involved to be given the chance to talk to each other when both feel able to do so, with one commenting: "Staff need to understand why patients are angry. When both the patient and member of staff want to meet, it would be unhelpful to stand in the way. But it does need to be considered on a case-by-case basis. It can crush some people".

3. Visibly and actively support staff when things become difficult, so they feel safe to be open and honest

Everyone recognised that learning is contingent on everyone telling the truth. Participants shared reflections on why staff are sometimes reluctant to engage with investigation and learning processes and what they can do to address those reasons.

Contributors agreed 'honesty' is not about 'good' and 'bad' people: staff need to feel 'psychologically safe' to engage in any process, and their readiness to do so comes from trust that they will be treated fairly and by overcoming their fears.

One participant noted that fear is complex. It's not only fear of punishment, but fear of examining one's own limitations, fear of being judged by their peers and those they manage, and even a general fear of having 'let people down'. That takes time to work through. They spoke of their own experiences of fallibility – "no clinician can say they haven't made a mistake in their life", but knew they had learned through experience and would manage this far better today than "someone young and scared".

Another participant observed that sometimes good people panic and say the first thing they think will "make it go away". If they do it's important to give them "'a way out" – a chance to share a less defensive account of how or why they made decisions without being branded a liar.

All participants had reflected on and used personal experiences of unjust culture to underpin their approach: "I swore I would never treat anyone like that, and I haven't in all my career".

The best way for a trust to address this staff fear is to work on how it can best support a member of its staff involved in an incident, and to give the clear message that it doesn't abandon people in times of trouble. One trust has a formal policy stating that when practice is called into question, a person's innocence is assumed until proven otherwise. They decided at board-level that no one would be suspended 'pending investigation'. But alongside this individual staff need to acknowledge and be honest when they are unable to perform safely even with all possible support given.

Supporting staff called to give evidence in coroner's court is another area that can be improved. One participant acknowledged that for many patients the coroner court process helps them get closure, but for some staff it can feel like "fear and dread". Several trusts have established structured support programmes for staff who are called to coroner's court. These programmes provide advice on what to expect and support if necessary, and their aim is to show that when things go wrong, it is right for there to be public scrutiny, but the challenge is to the organisation, not the individual: "we as an organisation are there with you".

The legal services in at least one of the trusts that was represented is now managed within the safety and governance team to ensure it's a supportive resource, and that the legal team understands the ethos of full and open investigation.

Participants mentioned how external initiatives can be useful to trusts in developing their just culture. For one trust, the NHS Improvement's A just culture guide has "come at the right time, it feels like a natural progression for us and it will fit into our work supporting people".

Participants discussed how Freedom to Speak Up guardians have brought about a powerful change. Although some felt that in an ideal world these guardians should not be needed, others welcomed them as another source of intelligence about what staff are thinking, and another role that can build trusting relationships. At least one trust houses the Freedom To Speak Up work within the safety and governance team to make its purpose clear, and staff are given awards to applaud staff for speaking out to challenge any sense that scapegoating will occur when people do raise concerns.

4. Invest in building good relationships with commissioners and regulators as they have a substantial impact on culture

All the trusts represented stressed how important it is to establish a good relationship with both commissioners and regulators. Most of the participants have generally good experiences with being open and transparent with these bodies and are trying to establish a high degree of trust, to make the relationship feel like a partnership.

They expressed a sense that the skills, interests and personalities of the individual regulators they link with do vary and this can pull trusts in different directions. Most participants had some experience of commissioners/regulators seeing their role as “to challenge everything no matter what’s been presented. Sometimes it’s a pedantic challenge”. Others worried commissioners and regulators’ focus was the number of Serious Incidents and the target timescales for completing reports, even when delays related to respecting the time families said they needed before becoming involved. They described consciously working to ensure that with a “plethora of emails” related to every investigation their natural response to scrutiny is not a defensive one. They believe it is important to be proactive and inclusive to shift their relationship with regulators and commissioners. “The tone that a regulator sets can have a disproportionate effect on staff when things go wrong. There’s a skill involved with engaging regulators, and when there are concerns, conscious efforts should be made to protect staff from the full brunt of regulatory interest”.

While the most important impact on just culture was felt to be the relationship between a trust and its local commissioners and regulators, central culture is important: “behaviours at the centre really do have consequences downstream”.

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