Implementation of a Just and Learning Culture at Mersey Care NHS FT

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NEARLY 8K STAFF

1 OF 3 providers of high secure services

Largest provider of learning disability forensic secure care

Over 80+ sites

£360M TURNOVER

100 STUDIES

Thriving research and development programme ranging from drug trials to bibliotherapy, app development to genomics.

4 LOCAL AUTHORITIES
- LIVERPOOL
- SEFTON
- KNOWSLEY
- ST HELENS

Working in Partnership

Serve a population of 11M in North West England and beyond

CQC OVERALL ‘GOOD’

Only high secure hospital to receive ‘good’ for safety.

97% of all contacts are in the community
Mersey Care Just and Learning Culture

For us at Mersey Care, a Just and Learning Culture can be seen as an environment where we put equal emphasis on accountability and learning.

It’s a culture that instinctively asks in the case of an adverse event: "what was responsible, not who is responsible".

It’s not finger-pointing and it’s not blame-seeking.

That said, a Just and Learning Culture is not the same as an uncritically tolerant culture where anything goes - that would be as inexcusable as a blame culture.
Background

- Trust commitment to patient care and experience BHAGS
- Feedback from staff and staff side: they wanted a BHAG for staff
- 2016 significant volume of disciplinary cases, a number of which led to Employment Tribunal
- Analysis of the cases from the previous year had shown that over 50% of investigations resulted in a case to answer
- Lengthy suspensions damaging for staff and services, also data showed impact on sickness following hearing outcome
- We had already improved the process to complete investigations quicker but the fundamental question remained did we need one in the first place
- Staff engagement sessions told the trust the overwhelming obstacle to staff transparency and delivery of care was their fear of the consequences, blame, shame or at worse dismissal
- Staff advised some of the trust processes both in HR & Patient Safety terms where negative experiences i.e. RCA processes.
Where we were

Ashworth staff confirm 24-hour strike after officers dismissed for "restraining" violent patient

Staff investigated over mental health unit deaths no longer suspended

POA calls for probe into unfair sacking

‘Targeted’ guards demand answers after wrongful dismissal.

An independent inquiry must be launched into the dismissal of two now-vindicated guards who restrained a notorious criminal with a slipper, the Prison Officers’ Association (POA) said yesterday.

Staff at Ashworth secure psychiatric hospital in Merseyside, which counts Moors murderer Ian Brady among its patients, went on strike over the incident in November 2015.

The restrained inmate Andrew Farnon was imprisoned for a hammer rampage in 2007 which left a man fighting for his life, in hospital. Guardian journalist Steve Smailes reporting.
2016: The starting point

Secure Division Disciplinary Cases: 2016

Local Division Disciplinary Cases: 2016

Understanding what happened
The Simplicity of What We Did

- Genuinely working with staff side to co produce
- Researched evidence
- Analysis of our data
- Development of documentation – focus on the initial stages of the process & how we determine if an investigation required

- Shift in mind-set of HR, staff side and managers
- Re-education of all
- Involving the employee
- In partnership we co developed & piloted a Just Culture ‘Decision Tree’ – although we have now tore this up as its retributioinal & still focuses on the ‘who’

- Learning from historical cases but also saying “I’m sorry”
- Meet hurt with healing – restorative culture
2017 to date: the impact of being ‘Just’

*Average length of investigations have also reduced from 9 months in 2015 to 2 months in 2018*
But it didn’t stop there
The impact of Learning ........

Interactive microsite “always available” with accessible information about what a Just and Learning Culture means:

- Videos
- Staff stories to share learning and assist prevention
- Contact information
- 200 word summary
- Meet the Ambassadors
- Quotes from staff side
- Downloads
- Regularly updated news
- Access to the new policies
- How staff can get involved
Impact of moving away from Policies that Punish to Policies that Support

The new Supporting Colleagues’ policy is central to our vision of Just and Learning.

We want everyone to feel supported by their colleagues and we want them to know they can access free and confidential services such as counselling and physiotherapy.

Toolkit includes a simple discussion checklist for managers to use when supporting a colleague after an incident.

Discussion paper for teams to explore during their regular meetings.

This policy recognises that individuals may react differently to events and that ultimately being both supportive and supported improves everyone’s wellbeing. It’s a great opportunity to talk about what ‘support’ looks like.
**IMPACT**

- From Jan 2016 to Dec 2017 the number of disciplinary investigations reduced by approx. 64% in our Secure Division and by approx. 56% in our Local Division. For the same period suspensions reduced by over 85% and 25% respectively.
- If examine Q1 2016 trust wide data and compare with Q1 2018 we can see a 59% reduction in disciplinary investigations, BUT during the same time period our workforce numbers have more than doubled.
- Trust wide average cost of disciplinary investigations between £2.5k and £5k per case, Trust wide pre 2017 cost between £217k – £435k a year.
- Now if average Q1 2018 costs for disciplinary investigations across a 12 month period it would be between £90k and £180k.
- Trust wide in 2016 clinical suspensions (including backfill) cost approximately £1.1m in 2016, 2017 £731k, 2018 cost so far £10k (if we average out for year approx £40k).
- Different conversations with staff side, managers and HR
- Staff are speaking out, and having conversations with teams about how they could improve patient care and how they learn from when things have not gone to plan.
- Staff are more prepared to share their vulnerability – this is being led from the top.
- Good CQC & 3 NHSI acquisition assessments in 3 years, J & L approaches viewed as extremely positive.
IMPACT

• Increase in incident reporting and overall reduction in harm
• Increase in local resolution of complaints
• Improvements in patient experience scores
• Increase in reporting adverse incidents
• Increase in staff seeking staff support but decrease in issues presenting re bullying.
• Staff Survey 2017 shows overall staff engagement and staff recommending the trust as a place to work or receive treatment improved, despite acquisitions of two trusts in difficulty
• Largest local changes since the 2016 survey are correlated with our J & L actions and include:-
  2. Staff confidence and security in reporting unsafe clinical practice from 3.73 in 2016 to 3.79 in 2017 (against average of 3.71).
What next

• Continue our journey
• Operational principles
• Recruit more ambassadors & have ambassador led projects
• Quality Account Objectives year 2
• New campaign – Hunt down policies that prevent practice, or language that is punitive
• Adopt approach into newest acquisition post Kirkup
• Launch of our film in partnership with Professor Sidney Dekker
• Continue to share our learning at various forums - Professional articles, talking at national forums & conferences (Partnership, HR & Patient Safety etc)
• Write up our implementation approach and lessons learnt for others, potential to create a national task force
• Conduct piece of research into economic case for restorative culture
Co-Produced

• By end of March 2019, 100% of leaders Band 7 and above will have been assessed and have a development plan to support their teams in a Just and Learning environment

• To support colleagues’ psychological safety through the development of bullying awareness for staff based on a preventative approach to recognise bullying behaviour and develop a process to resolve issues

• To develop a standardised framework to support learning from incidents including supporting staff, how to debrief, and to provide governance and validation mechanisms to improve the safety and experience of the people we service and our colleagues so that risks are addressed and learning is maximised

• Produce a guide for colleagues and service users on Just and Learning expectations to describe the shared responsibility between individuals, teams and the organisational to create a safe and compassionate environment
Our Reflections

http://sidneydekker.com/just-culture/