Just & Learning Culture

‘…..when it is ok to tell the boss bad news…..’

Amanda Oates– Executive Director of Workforce
Mersey Care NHS Foundation Trust
@amandajoyoates
• An introduction to Mersey Care
• Our people plan journey
• A Just Culture
• Our Just and Learning breakthroughs
Welcome to Mersey Care

1 OF 3 providers of high secure services

NEARLY 8K growth from 5,000 in 2016

ONE OF ONLY FIVE NHS INPATIENT ADDICTIONS SERVICES IN THE COUNTRY

3,500+ social prescriptions since January 2017

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

780 BEDS across nine hospital sites

~2 MILLION community contacts/year

BIGGEST IAPT SERVICE IN THE NHS

£370M TURNOVER up from £250m pre LCH acquisition

FOR OUR LOCAL SERVICES LOCAL AUTHORITIES
- LIVERPOOL
- SEFTON
- KNOWSLEY
- ST HELENS

Largest provider of learning disability forensic secure care
• An introduction to Mersey Care
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The foundation of our approach to developing our people plan

Foresight
The organisation we want to be and services we want to provide

Insight
Co-produced with our patients, staff, Just & Learning Ambassadors, unions – side by side

Oversight
Provided with candour, fairness, transparency and learning
Our People Plan – a culture that enables people to be the best they can be
Where we were in the Mersey Care?
Barriers to Transparency

- Fear of consequences, blame, shame and being dismissed
- Lack of support or trust, ‘adversarial’
- Incident investigations
- Lack of feedback . . .
The Context and Challenge of our People Plan journey
- Pre 2016

- Staff survey results showed concern about fairness and reporting of incidents;
- Pre 2016 significant volume of disciplinary cases, 50% of investigations resulted in NO case to answer;
- Lengthy suspensions damaging for staff and services;
- Policy & Process improvements in place – but rule based;
- Staff engagement sessions told the trust the overwhelming obstacle to staff transparency in delivery of care was their fear of the;
- Staff advised some of the trust processes both in HR & Patient Safety terms where retributively focused– who did something wrong, what are the consequences, we need more rules, people are the problem;
- Retributive emphasis in our language – investigations, hearings, allegations, disciplinary action, tribunals, mistrust;
- NO/IMPAIRED LEARNING, therefore NO/PARTIAL PREVENTION.
Where we were

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

The Prison Officers' Association said members voted overwhelmingly for action at the high-security hospital in

Staff investigated over mental health unit deaths no longer suspended

Three people died at the Broadhead Unit within three months of each other.

The U.K. inquiry into the Broadhead Unit at Broadhead Hospital was investigate following three separate tragedies, between October and February.

One of those was the death of deranged Paul Harrison, a 55-year-old who hung himself just five days after being brought to the hospital after a court order in January 2017.

Another was that of Eddie Easton, 41, who died in October 2017 after around nine weeks of the same.

The third tragic death was that of 26-year-old Laura Mackenzie, who was staying in the hospital ward before his death in February 2015, and whose request to see family members was denied.

The Prison Officers' Association (POA) confirmed staff will walk out from 7am on Friday, November 13 at Ashworth psychiatric hospital in Maghull.

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 Fardoun was imprisoned for a hammer rampage in 2007 which left a man fighting for his life.
Staff wanted a People Plan but they also wanted a staff BHAG ....

...they wanted to work in a safe place, be treated fairly and compassionately, and so our Just & Learning Culture was born....
• An introduction to Mersey Care
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A Just Culture

A just culture accepts nobody’s account as “true” or “right” and others wrong … Instead it accepts the value of multiple perspectives, and uses them to encourage both accountability and learning.

Sidney Dekker
Retribution

- Which rule is broken
- Who did it
- How bad is the breach
- What should the consequences be
An ‘officialised’ approach

- People are the problem
- Find out what people did wrong
- Write more rules
- Tell everyone to try harder
- Get rid of bad apples
- Investigation
- Hearing
- Witness
- Allegations
- Recklessness/Negligence/Misconduct/ Gross Misconduct
- Disciplinary action – sanction
- Suspension
- Warning
But...it’s counterproductive

- Learning
- Team
- Review
- Humanity
- Compassion
- Forgiveness
- Understanding
- Restoration
- Healing
- Trust
Restoration

• Who is hurt
• What are their needs
• Whose obligation is it to meet those
• How do we involve the community
Goals of restoration

• Moral engagement
• Emotional healing
• Reintegration of practitioner
• Organisational learning
• Prevention
Mersey Care’s Just and Learning Culture

• Delivering our ambition for Perfect Care depends on the development of a **non-punitive culture**;

• Learning can only flourish when responses to mistakes are **compassionate**;

• Personal **responsibility** and **professional accountability** drives the organisational learning;

• It’s not about 'blame-free' or being tolerant of absolutely anything;

• It’s a careful balance of accountability and learning;

• **A prospective** outlook rather than a **retrospective** bias;

• Ask **what and how**, not **who** because a bad system will always beat a good person.

**A Just Culture** *(from Sidney Dekker)*

• Brings out information about improvement to levels/groups able to do something about it;

• Allows the organisation to invest in improvements that have a safety dividend, rather than deflecting them into legal defence and liability protection;

• Simultaneously satisfies demands for accountability and the need to learn and improve.
What We Set Out to Achieve in 2016 – *putting the human back in HR*

**Objectives - 1. Reduce ER activity and suspensions**

**Organisation Learning**
- Research evidence
- Rebuild Staff Side relations through a partnership approach
- Learn from our data and processes
- Develop documentation that supports a different approach

**Modify Language**
- Less punitive language
- Feedback loops
- Myth-busting
- Move away from errors / wrong

**Piloted**
- New documentation and work from ‘Who’ to ‘What’
- Piloted Just Culture ‘Decision Tree’ to reduce ER activity

**Change in Priorities**
- Reduced inclination to start investigation
- Fewer **errors** resulting in suspensions
- Safety vs. Rules
- Re-integrating of practitioner
- Blame to learning
- Meet hurt with healing
- Forward looking accountability
- Raising concerns
What We Set Out to Achieve 2017 onwards

Objectives -
2. Increase support to colleagues & enable learning to improve safety
3. Improve staff survey results re confidence in raising concerns

Supporting Colleagues
• Established a Just & Learning Committee
• Improved support of staff
• Just & Learning Ambassadors
• Trained staff in Just Culture

Enable Learning & Improve Safety
• Developed an inter-active microsite
• Changed 72 hour review process and support
• Share good practice/success
• Moving away from policies that punish to policies that support
What we set out to achieve 2018

Systematising by March 2019

• **All leaders** as part of their appraisal will have been **assessed** and have a development plan to support their teams in a Just and Learning environment

• **Supporting 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

• **Just & Learning ‘Check In’ process** (like Toyota’s ‘Line Stop’)
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Just and Learning Culture: 2016 - 2018

Impact of restorative practice on live disciplinary cases and suspensions in local and secure divisions

- **54% Reduction** in disciplinary investigations in two years
- **£1.7m Saved** in clinical suspensions in two years

= Safety Dividend
The real dividend is safer patients and staff

- 20 suicides avoided in three years
- 684 restraints avoided in last 12 months
- 87 staff suspensions avoided in two years
- 222 disciplinary investigations prevented in two years
Value Creation: 2017 breakthroughs.

- A 54% reduction in disciplinary investigations whilst our workforce numbers have doubled;
- Direct salary cost of conducting an investigation reduced by over 50%;
- 2017 survey results are correlated with our J & L actions and include:
  - Fairness and effectiveness of procedures for reporting errors, near misses and incidents from 3.63 in 2016 to 3.70 in 2017;
  - Staff confidence and security in reporting unsafe clinical practice from 3.73 in 2016 to 3.79 in 2017 (against average of 3.71);
- Increase in staff raising concerns through Freedom to Speak Up Guardian
- Turnover reducing and better than average
- Increase in incident reporting and overall reduction in harm
- Increase in local resolution of complaints
- Improvements in patient experience scores

ROI of £1.8M = safety dividends
Value Creation 2018 Breakthroughs

2018 Staff Survey Results – Safety Culture

Overall staff culture theme 6.9 against an national average of 6.8

<table>
<thead>
<tr>
<th>Question</th>
<th>2018 Score</th>
<th>Trend</th>
<th>2017 Score</th>
<th>Trend</th>
<th>National Average</th>
<th>Comparison with National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q17a- My organisation treats staff who are involved in an error, near miss or incident fairly</td>
<td>55.0%</td>
<td>▲</td>
<td>45.9%</td>
<td>Statistically significant improvement</td>
<td>58.0%</td>
<td>Consistent with national average</td>
</tr>
<tr>
<td>Q17c- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again</td>
<td>73.5%</td>
<td>▲</td>
<td>66.4%</td>
<td>Statistically significant improvement</td>
<td>70.2%</td>
<td>Consistent with national average</td>
</tr>
<tr>
<td>Q17d- We are given feedback about changes made in response to reported errors, near misses and incidents</td>
<td>64.6%</td>
<td>▲</td>
<td>59.7%</td>
<td>No significant change</td>
<td>61.7%</td>
<td>Consistent with national average</td>
</tr>
<tr>
<td>Q18b- I would feel secure raising concerns about unsafe clinical practice</td>
<td>76.0%</td>
<td>▲</td>
<td>73.9%</td>
<td>No significant change</td>
<td>73.3%</td>
<td>Consistent with national average</td>
</tr>
<tr>
<td>Q18c- I am confident that my organisation would address my concern</td>
<td>66.3%</td>
<td>▲</td>
<td>64.1%</td>
<td>No significant change</td>
<td>60.0%</td>
<td>Better than national average</td>
</tr>
<tr>
<td>Q12b- My organisation acts on concerns raised by patients / service users</td>
<td>78.0%</td>
<td>▲</td>
<td>76.9%</td>
<td>No significant change</td>
<td>73.9%</td>
<td>Consistent with national average</td>
</tr>
</tbody>
</table>

* In our community division following acquisition on 1<sup>st</sup> April 2018 (post Kirkup enquiry) 10% improvement
Systemising Change
Just and Learning: Distinguishing Causality vs Contribution

Who is responsible
Punitive & adversarial investigation
Legal sanction

What is responsible?

Organisational accountability
Professional accountability

Psychological safety
Candour Reflection De-brief
Forward Looking accountability

- Handover
- Clinical governance
- Staffing level
- Technical lapse (IT system)

- Supervision
- Training/induction
- Practitioner lapse (competency or conduct)
Systemising Change
Learning from the every day routine, not just incidents

Traditional safety uses a small portion of the total experience base.

Unwanted outcomes

Planned Outcome

Positive Surprises

What about the 99.999% of the time in which things go right?

Do we understand why success is the rule and not the exception?
JUST & LEARNING OBJECTIVES FOR 2019/2020

1. Developing and implementing a tool / framework to support restorative conversations in practice.

2. Developing a tool/framework, aligned to our organisational values that fosters and supports civility in practice.

3. Every team to have Just and Learning conversations, highlighting learning from routine with processes working well, alongside learning from processes when something doesn’t go to plan.

4. Refresh the datix pro-forma’s, the process, training offered and guidance on completion.
2018 Staff Survey Safe Environment Theme

**Building on from 2018 into 2019**

**Overall Experience:**
- Meets National Average

**Abuse from patients:**
- Worse than national average

**Bullying /harassment from managers:**
- Slightly better than national average

**Bullying /harassment from colleagues:**
- Slightly better than national average
Respect & Civility Workstream

“to explore the reasons and impact of miscommunication and poor behaviour, empowering staff to challenge and change culture.”

• Raise awareness and empower staff to challenge poor behaviour and choose respect, reinforcing civility and positive culture.

• To develop a comprehensive training programme to enhance emotional intelligence as to how behaviours can be perceived and received.

• Triangulate data sources to measure and evaluate impact.

• Developing a tool/framework, aligned to our organisational values that fosters and supports civility in practice.’

• https://www.youtube.com/watch?v=A_fSngtv9Pc
Summary

• We have focused putting the human back in HR;
• Apply an OD approach – diagnostic and dialogic;
• See your people as the solution and not the problem;
• Culture that allows the boss and HR to hear bad news;
• Co-produced approach with staff, unions, ambassadors and patients/users;
• See transparency and openness as allies not enemies;
• Moving to learning from our routine work;
• We are all human – show it
• To create the best safety culture, staff have to feel safe themselves
What’s Next

JUST and LEARNING CULTURE

A new way of caring

Amanda Oates, Executive Director of Workforce
Restorative Culture in Practice

We will explain the difference between retributive and restorative approaches, and consider the pros and cons of each. We will discuss how a Restorative Culture can be evident even without adverse events. We address the role of the human resource professional in initiating and sustaining a Restorative Culture. We will also outline how Mersey Care took an organisational development approach to diagnosing and tailoring its approach through staff engagement.
Thank you

Just Culture The Movie

https://www.youtube.com/watch?v=LCFcvekVWGM&feature=youtu.be

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