NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

OUR RESTORATIVE JUST AND LEARNING CULTURE: APPLICATION TO PATIENT SAFETY AND INNOVATION

JUNE 2020

SETTING THE SCENE: OUR MERSEY CARE STRATEGY

Since 2012, Mersey Care NHS Foundation Trust has been recognised for delivering a strategy for Perfect Care within a restorative just and learning culture. Initially a mental health Trust with high, medium and low secure services, community and inpatient mental health, learning disability and addictions services the Trust has doubled in size with the acquisition of Liverpool Health Care and now includes all community physical health services in Merseyside, with a workforce that has increased from 3,500 to 8,000 staff in the last 3 years.

With the aim of achieving genuine integration for the delivery of bio, psycho, social care, an acquisition is planned for next year of North West Boroughs NHS Foundation Trust. Mersey Care will subsequently be the largest community mental and physical health provider in the UK, with a workforce of 12,500.

Through this period of significant change, the Trust has continued to improve its quality indicators, staff indicators, and maintain financial balance (despite acquiring Trusts in difficulty), which is a rarity in the NHS.

Table 1: The Mersey Care Strategy

Our services: Strive for Perfect Care	Our people: Become the employer of choice in our sector	Our resources: Develop a solid financial, estate and digital platform for future integration	Our future: Work with and learn from others to have greater Impact
Improving quality: Perfect Care	Becoming an employer of choice in our sector	Maintaining financial balance	Developing Provider Alliances

Improving quality (STEEP): Continuous improvement	Restorative Just and Learning Culture	Improving our estate	Research and development
Population health	Working side by side with service users and carers	Invest in digital technology	Commercialising our knowledge assets
Integration			

At the heart of all that is done in Mersey Care is the commitment to 'perfect care' – care that is safe, effective, positively experienced, timely, equitable and efficient, with our own stretching targets for improvements in care. This underpinned by the Trust aspiration for a restorative just and learning culture, with compassion, fairness and civility engrained into day-to-day life and an emphasis on learning from mistakes and asking what the problem is instead of who is to blame. Crucial ambitions are framed into big audacious goals, and staff demanded a staff BHAG around a culture change. They wanted to work in a safe place, be treated fairly and compassionately, and so the Restorative Just & Learning Culture was born.

ENABLERS: UNDERPINNING PRINCIPLES AND EXPERTISE

COMPASSIONATE, COLLECTIVE LEADERSHIP AND TEAM WORKING – MICHAEL WEST INNOVATION AND QUALITY IMPROVEMENT

Contributing to the creation of a restorative just and learning culture, leadership development at Mersey Care strives to enable team leaders to develop strategy and deliver operational performance, in terms of high-quality care, staffing, finance and resources, and brokering dialogue between the Board and clinical and operational teams. Leaders are encouraged to be compassionate and listen to their teams and they are invited to be collaborative, engendering entrepreneurial capability and new ideas for teamwork and operational delivery. A constant commitment to quality of care and being able to describe shared vision, purpose, values and aspirations to their senior leaders and their teams and vice versa, enables influence and initiative to develop, outcomes to improve and innovation to spread. Ensuring effective, efficient and performance by ensuring there are clear priorities and objectives at every level and intelligent data constantly informing all about performance. Support, compassion and inclusion for all patients and staff are crucial, making sure all interactions involve careful attention, empathy and intent to take intelligent helping action.

A high performing team framework and development programme supports the team leaders to embed structure and process into their teams, providing the mechanics of effective team work and the method of articulating purpose, operating principles and membership together with interdependent working practices. Decision making is made by a team rather than an individual, as close as possible to the patient or service user and their needs. Enthusiastic cooperation, team working and support within and across divisions and services within the Trust is enabling the taking responsibility for improving quality, learning and developing better ways of doing things

Programmes of engagement encourage collaboration and commitment within teams, and across the Trust, with quality improvement programmes in order to firmly embed effective change. Continuous learning, quality improvement and innovation, taking responsibility for improving quality, learning and developing better ways of doing things and essential together with taking learning from restorative practice and making improvements and developing services.

All themes of work are interconnected and inter related, leading to reinforcing principles and common language, ensuring robust and confident strategy is translated into operational excellence at all levels.

OUR RESTORATIVE JUST AND LEARNING CULTURE

PSYCHOLOGICAL SAFETY – AMY EDMONDSON

RESTORATIVE JUST AND LEARNING CULTURE, AND RESTORATIVE PRACTICE – SYDNEY DEKKER

Psychological safety is present when colleagues trust and respect each other and feel able, even obligated, to be honest. It is the ability to show and employ yourself without fear of negative consequences. Mersey Care leaders are purposefully building psychological safety by setting the scene for their team: framing the work and emphasising purpose, followed by inviting participation from team members through demonstrating situational humility, practicing inquiry and setting up structures and processes. Productively responding is also crucial to ensure psychological safety by expressing appreciation, destigmatising failure and sanctions for clear violations.

In this culture of clarity, cooperation, structure and processes, restorative just and learning comes in to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed.

A restorative 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).

In a culture of **Retribution,** the questions that are asked include: Which rule is broken? Who did it? How bad is the breach? What should the consequences be? This approach however is counterproductive to learning and the team and their method of review and also in terms of enduring trust, humanity, compassion, forgiveness, understanding and healing.

In a culture of **Restoration**, the questions are quite different, asking: Who is hurt? What are their needs? Whose obligation is it to meet those needs? How do we involve the community? The goals and outcomes to approaching situations that do not proceed as planned in this way include: moral engagement, emotional healing, the reintegration of practitioner into their work, learning for the organisation and prevention to avoid the adverse event being repeated in the future.

A culture that instinctively asks in the case of an adverse event: "what was responsible, not who is responsible", is not finger pointing and not blame-seeking. However, it is not the same as an uncritically tolerant culture where 'anything goes' as that would be as inexcusable as a blame culture.

A restorative justice culture compassionately asks those involved to give an account of how the event happened and what it meant to those involved. Together, it is determined how to meet the needs that have arisen. By reviewing an event in this way, the differences between 'work done' and 'work imagined' can become clearer, and when and what changes would make a difference can be identified. Work as imagined can be described as 'what we think people do'. Work as prescribed is 'what we would like people to do', as described in policies and operating procedures. Work as disclosed is 'what people tell us they do' and work as done is 'what people actually do'[1].

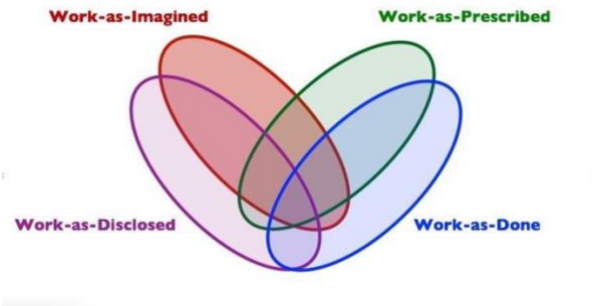

Figure 1 Work as Done

Allowing collective learning and restoration from practice, process and mistakes gives the opportunity for change; bringing out information about possible improvement to groups able to take action. This could be making processes more efficient and effective, cutting out waste, introducing innovation and reducing

[1] As suggested by Suzette Woodward https://suzettewoodward.org/2020/03/24/safety-ii-and-covid-19/

bureaucracy. This allows the organisation to invest in improvements that have a safety dividend, rather than deflecting them into legal defence and liability protection. A restorative just and learning approach simultaneously satisfies demands for accountability and the need to learn and improve. Learning from experiences and adverse events can require an improvement to processes and circumstances which quality improvement methodologies can directly support; another Mersey Care area of focus.

Mersey Care worked with Sidney Dekker to develop the Trust's approach to a restorative just and learning culture. Sidney is a widely respected academic, Safety II pioneer and has also been a First Officer on Boeing 737s in Europe. In Sweden, he was Professor of Human Factors and System Safety and in Australia Sidney founded the Safety Science Innovation Lab. His book "Just Culture" has become a standard text for organisations across the world who are redefining what accountability means, offering a way for workplaces to respond to mistakes and restore relationships and trust. Sidney's studies of patient safety and understanding human behaviours are a celebration of the expertise that makes things go well and offer compassion when they don't.

For Mersey Care, delivering the ambition for Perfect Care depends on the development of a non-punitive culture; with personal responsibility and professional accountability driving the organisational learning, and a prospective outlook rather than a retrospective bias ensuring the focus on the future and the next event. Recognising all systems are not perfect, the emphasis is always on asking what and how, not who, because a bad system will always beat a good person.

PATIENT SAFETY 2

The principles of restorative just culture can be applied widely, and especially when reviewing incidents from the patient perspective.

National programmes of work around patient safety have emphasised the importance of treating staff fairly if things go wrong or they speak up about something they think is wrong. The call has been heard to explore the inter-relationship between complaints and incidents – not least the assertion that complaints are a form of incident reporting. People do not necessarily know how to differentiate between a complaint and safety information to support learning; but they need to feel confident to speak up.

While acknowledging the complaints system is established in law, Mersey Care is exploring this challenge with system partners to create more opportunities for improvement. The Trust is applying the principles of restorative just and learning cultures to patient safety, considering: System – empathy and compassion, Personal – focus on the value dimension and Service – adopt systems thinking and human factors approach. The aspiration is concerned with reflecting, capturing and taking the learning now so we can narrow the gap between work done and work imagined.

When applying the work imagined, work done concept to safety, clear lessons can be learned. Safety as imagined includes the philosophy that increased incident reports will indicate a good safety culture and system, root cause analysis will enable the problems to be found and fixed, zero harm can be reached and never events eradicated, levels of harm are known and people can reduce them and if focus is maintained on individual areas of harm safety will be improved eventually.

In reality, safety as done is often describes as incident reports being data which will provide an indication of areas of concern or failure, root cause analysis is an outdated methodology for a complex adaptive system, zero will never be reached, the do not know the true level of harm is not known and purely focusing on individual areas of harm is like 'rearranging the deckchairs on the titanic while the ship sinks.'[2]

For staff to deliver safe and effective care they need to feel supported within a compassionate environment with psychological safety being imperative so that each member of staff knows that they will be treated fairly and compassionately if care does not go as planned. This supports a culture of speaking up to stop problems occurring and creating the ideal environment to nurture quality and safety improvement.

The traditional view of safety (Safety I), has been defined by the absence of accidents, complaints, claims and incidents, especially never events, significant, serious incidents and deaths or as the 'freedom from unacceptable risk.' This is using a small part of the total experience bases; the unwanted outcomes. As a result, the focus of safety research and safety management is on unsafe system operation rather than on safe operation. Approaches and language could bias investigations towards negativity, blame, individual sanction and fear without accounting for complex adaptive systems in circumstances that are not linear or fixed. In contrast to the traditional view, resilience engineering found in newer approaches to safety, maintains that 'things go wrong' and 'things go right' for the same basic reasons. By looking at the times that things go right, levels of understanding are built to know why success is the rule and not the exception; systemising learning from everyday routine not just incidents.

As outlined in The NHS Patient Safety Strategy (2019) Mersey Care is committed to widening patient safety thinking not just addressing when care does not go as planned (Safety I) but also what regularly works and works well as planned (Safety II), building on the foundations of restorative just and learning culture. Safety-II defines safety as the ability to succeed under varying conditions; not just focus upon the exceptional. It is also about understanding routinely delivered safe and effective care. In the Safety-II construct, the focus is on making systems safer by understanding day to day care better. Care goes as planned with good outcomes most of the time, and by studying and understanding what happens most of the time, the conditions which support safe and effective care can be identified, replicated and strengthened.

[2] Suzette Woodward

The focus on safety is intended to support the development of learning within teams focussing upon:

- Reflecting upon and analysing routine care to better understand how it works day to day; use positive language to describe circumstances
- Recognise the exceptional as a platform for addressing when care does not go as planned; this instils optimism and recognises the good work of others and creates positivity in the workplace
- Recognise what can be done by the team and act; this ensures empowerment
- Take a multiple professional cross-system perspective to introduce new views and potential solutions to problems

APPLICATION IN PRACTICE

Mersey Care has found that the introduction of a restorative just and learning culture with restorative justice has coincided with many qualitative improvements for staff, such as a reduction in suspensions and dismissals, an increase in the reporting of adverse events as staff feel safe to do so, an increase in the number of staff that feel encouraged to seek support, a slowing down of the upward trend in absence due to illness and an improvement in staff retention. The Trust has seen a 54% reduction in disciplinary investigations in two years, 410 disciplinary investigations prevented and 166 staff suspensions avoided since January 2017.

The economic benefits of restorative justice appear significant. After corrections for inflation, acquisitions and anomalies, it has been found that the salary costs averaged over two fiscal years were reduced by £4 million per year, coinciding with the introduction of a restorative just and learning culture in 2016. In addition, Mersey Care reaped around £1 million in saved legal and termination expenses; conservatively half of these savings have been attributed to the introduction of a restorative just and learning culture itself, and the other half to non-related factors. Using this assumption, it is estimated the total economic benefit of restorative justice in the case of Mersey Care NHS Foundation Trust to be about £ 2.5 million or approximately 1% of the total costs and 2% of the labour costs and £1.7m saved in clinical suspensions in two years

Many staff have been able to share their experiences of how a restorative just and learning culture has ensures they are able and supported to share their views and experiences, restorative justice is applied to adverse events and as a result learning and the implementation of productive changes has increased and the outcome has been an improvement in staff engagement, innovation and patient safety, with data being reviewed to support this result.

RESTORATIVE JUST AND LEARNING CULTURE IN CLINICAL PRACTICE

Hardworking NHS staff must not be admonished for making genuine mistakes but the root causes must be addressed. In a recent incident a District Nurses made a potentially serious drug error, giving insulin to the wrong patient. Although very distressed, and fearing inevitable disciplinary action, the nurse in question reported events immediately to her line manager, seeking support to ensure the safety of the patient. The Team Leader attended immediately at the patient's home and established a protocol of blood sugar checks being conducted three times daily, the leader offered support to the nurse in question and took all necessary actions to mitigate the impact of the error. She also recognised this as a genuine learning opportunity, role-modeling the way of dealing with such incidents should it be needed in the future. Back at base the Team Leader then facilitated a wider discussion; identifying contributory factors and actions that could be taken as a team to prevent any recurrence. The psychological safety that was reinforced by the fair treatment of the nurse involved and the inclusion of all team members in learning from the situation allowed for changes to be made to the medication process. Patient safety was ensured in this situation with the added benefit of valuable learning, but also the nurse in question also fed back she felt fully supported by the Team Leader and would not feel frightened or scared to report incidents in the future. The District Nurse Team reported that the situation had been well handled and that there was no need to wait for an incident to occur to review working practices.

A second example also acknowledges the clinical compassionate leadership that characterises a restorative just and learning culture. Two serious incidents involving harm to people that use community services occurred. Both of these incidents involved a number of practitioners from across multiple Mersey Care services, including Early Intervention Team, Community Mental Health Team and an Accident and Emergency department. The lead Consultant for the service showed exceptional leadership by arranging and facilitating debriefs for both incidents, inviting and involving people from each service. This was done to ensure that those involves could reflect in a psychologically safe way and learn from the incidents to improve the safety of service and to ensure that all staff felt supported, safe and cared for. A member of staff in a senior position may have responded traditionally to these sorts of challenging circumstances with a narrative of "What haven't you done? or "Who has messed up?". Historically, few Consultant Psychiatrists would have arranged debriefs. The practitioners had a safe space to reflect on the care provided and to acknowledge excellent practice despite the unfortunate circumstances. The identification of lessons learnt was encouraged so that the team processes could be adapted to try and prevent similar incidents occurring in the future and immediate changes to team processes were implemented. Staff involved reported that it was incredibly inspiring to see this process being implemented as a part of everyday business, and that this was the most supportive care that they had ever received following a serious incident.