



An Stiúrtóireacht um Ardchaighdeán
agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and
Patient Safety Directorate
Office of the Chief Clinical Officer

QPS TALKTIME



A community of quality and patient safety improvers

Tuesday, 27th September, 2022

“Restorative Just Culture” with Prof. Joe Rafferty & Amanda Oates

How we are running today's session



- You will be muted but the chat is open throughout - please post any questions or comments there and we will address them after the presentation.



- If your tech fails, don't worry – we're recording it so you can watch video and access the slides at your convenience. Audio is available via your PC or dial in:

Telephone no: Irish: 01-5260058 / UK: +44-20-7660-8149

Event number: 2734 463 5040

Please feel free to continue the discussion on Twitter: @JR_MerseyCare

@amandajoyoates @Juanitaguidera @johnfitzsimons9 @mapflynn / @QPSTalkTime / @NationalQPS / #QIreland #patientsafety



- Please help us to improve our QPS TalkTime Webinars by completing a short feedback form (pop up window before you log out).



- Please note the ChatBox will also be saved for learning purposes.



- You will receive an email from QPS TalkTime confirming your attendance.

- **To get started ... we invite you to**

Share using the chat box

- Your name, work and where you are joining us from ...
- Finish this statement:

Have you ever made a mistake and how did that make you feel...

Speakers today



Professor Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust. The trust is now one of the largest specialised integrated care providers in the NHS and includes inpatient and community mental health, community physical health, and learning disability and addictions services.



Amanda Oates, is an NHS Directors of Human Resources and Organisational Development in the North West. Her extensive experience includes Director level posts in a number of NHS trusts and she has operated at the most senior board levels since 2008.

In conversation with



Dr. John Fitzsimons, Clinical Director with the National Quality and Patient Safety Directorate and Consultant Paediatrician at Children's Health Ireland at Temple Street



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WELCOME

Joe Rafferty
Chief Executive Mersey Care NHS FT

Amanda Oates
*Executive Director of Workforce,
Mersey Care NHS FT*



What kind of culture - Restorative or Retributive?

11,340
STAFF | One of the **LARGEST**
healthcare employers
in the North West

997
BEDS

1 OF 3
providers of high
secure services



£
OVER
£573M
TURNOVER

The biggest
IAPT
SERVICE
in the NHS

Over
100,000
LIFE ROOMS
VISITORS

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

ONE of only FIVE NHS
inpatient addictions services
in the country

6 FOR OUR LOCAL SERVICES
LOCAL
AUTHORITIES

- LIVERPOOL
- SEFTON
- KNOWSLEY
- ST HELENS
- HALTON
- WARRINGTON

New provider of
community services
across Sefton

5,000+
social prescriptions
since January 2012

Largest provider of
learning disability
forensic secure care





Our vision is to strive for perfect, whole-person care that helps people live happier, healthier lives.

Community and Mental Health Services

OUR GOALS

OUR SERVICES - Combine clinical excellence with prevention and care coordination in our services

OUR PEOPLE - More people choose to work at Mersey Care and service users feel they have more control over their health

OUR RESOURCES - Use our buildings, IT and money to enable clinical excellence with prevention and care coordination in our services

OUR FUTURE - Be a good partner organisation and strive for new advances in care and treatment



STRIVING FOR PERFECT CARE

Stretching goals to keep us at the forefront of challenges and maintain our leading safety status.

ZERO acceptance of racism, discrimination and unacceptable behaviours

ZERO restrictive practice

ZERO suicide

ZERO harm from medication

ZERO falls in our care



OUR VALUES

The way we will achieve our vision, mission and goals - built on a solid foundation of restorative just and learning culture.



C Continuous improvement - committed to making improvements to our services for the benefit of all

A Accountability - taking ownership to anticipate, develop and deliver high quality care

R Respect - how we treat others in an inclusive and supportive way

E Enthusiasm - demonstrate our passion and pride for what we do and how we do it

S Support - actively supporting others with compassion and courage

April 2022



What is a Just Culture?

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

© Mersey Care NHS Foundation Trust

Why is a having a good Trust Culture Important?

- Culture matters because it offers a way for employees to understand their organisation, to voice their views, and to develop connections and common purpose.
- It's also important to continually assess that culture, as the organisation's purpose and values will affect the standard of its customer service and influence the engagement and retention of its people.



NHS

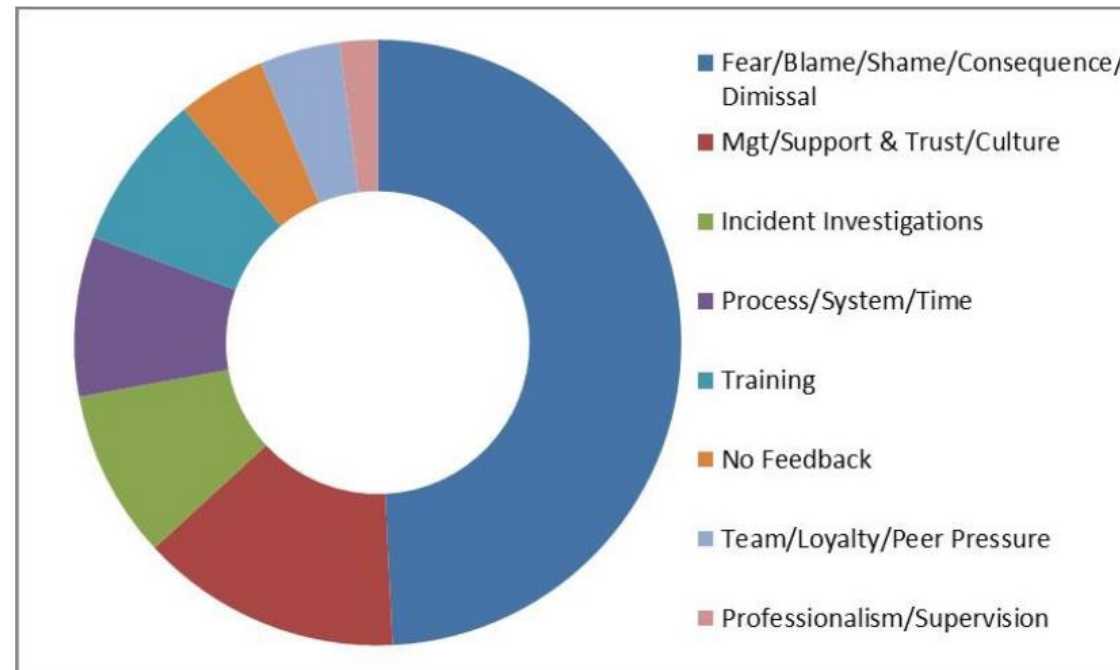
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Retributive the impact on staff

Business rational for changing for Mersey Care

- Fear of consequences, blame, shame and being dismissed
- Lack of support or trust, 'adversarial'
- Incident investigations
- Lack of feedback . . .



A large iceberg floating in the ocean. The tip of the iceberg is visible above the water surface, while the much larger, submerged part of the iceberg is visible below the surface. The sky is blue with light clouds, and the water is a deep blue.

Staff wanted a staff perfect care goal

...they wanted to work in a safe place, be treated fairly and compassionately, and so our Just & Learning Culture was born....

Our Restorative Just and Learning Culture

A Just Culture (from Sidney Dekker)

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



Developing 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
- It distinguishes between **causation** and **contribution** and **work done V work imagined**
- A **prospective** outlook rather than a **retrospective** bias
- Ask **what** and **how**, not **who** because a bad system will always beat a good person.

Organisational Performance & Organisational Health



- Historically the focus of many organisations has been on their organisational performance.
- Evidence today suggests that the best way to run an organisation is to balance short-term organisation performance and long-term organisation health.
- NHS Improvement Single Oversight Framework (SOF) metrics from 2017/18 only 56% of SOF metrics on target. In 2021/22 the Trust was achieving 92%.

Top 6 areas of focus

1. Building Psychological Safety was critical

Setting the Stage	Inviting Participation	Responding Productively
<p>Frame the Work</p> <ul style="list-style-type: none"> Set expectations about uncertainty, failure and interdependence to clarify the need for voice <p>Emphasise Purpose</p> <ul style="list-style-type: none"> Identify what's at stake, why it matters, and for whom it matters 	<p>Demonstrate Situational Humility</p> <ul style="list-style-type: none"> Acknowledge gaps <p>Practice Inquiry</p> <ul style="list-style-type: none"> Ask good questions Model intense listening <p>Set Up Structures and Processes</p> <ul style="list-style-type: none"> Create forums for input Provide guidelines for discussion 	<p>Express Appreciation</p> <ul style="list-style-type: none"> Listen Acknowledge and thank <p>Destigmatize Failure</p> <ul style="list-style-type: none"> Look forward Offer help Discuss, consider, and brainstorm next steps <p>Sanction Clear Violations</p>

Amv Edmondson

Psychological safety is the belief that you won't be punished, humiliated rejected for speaking up with ideas, questions, concerns, or mistakes.

2. Have a framework

Our Just and Learning Culture has shaped how we have approached improvements in our people processes.

This supports the Trust aim for Perfect Care for all of our patients and service users.

STEP 3 – MERSEY CARE GATEWAY

STEP 2 – ALWAYS REMEMBER

STEP 1 – TRIGGER POINT

The adverse event/incident

An event that could have caused or did result in harm to people or groups of people. This can include psychological harm and feelings of hurt, or physical harm even or damage to property.

and/or people external to our organisation

What is their need? Support, include clear communication plan, regular and timely. Consider staff support policy, interventions, etc.

Whose obligation is it to meet that need? Someone especially assigned to ensure the restorative process is properly applied

What is the understanding of what happened? Did it make sense?

Are the resources available and appropriate?

3. Work as imagined & work as designed



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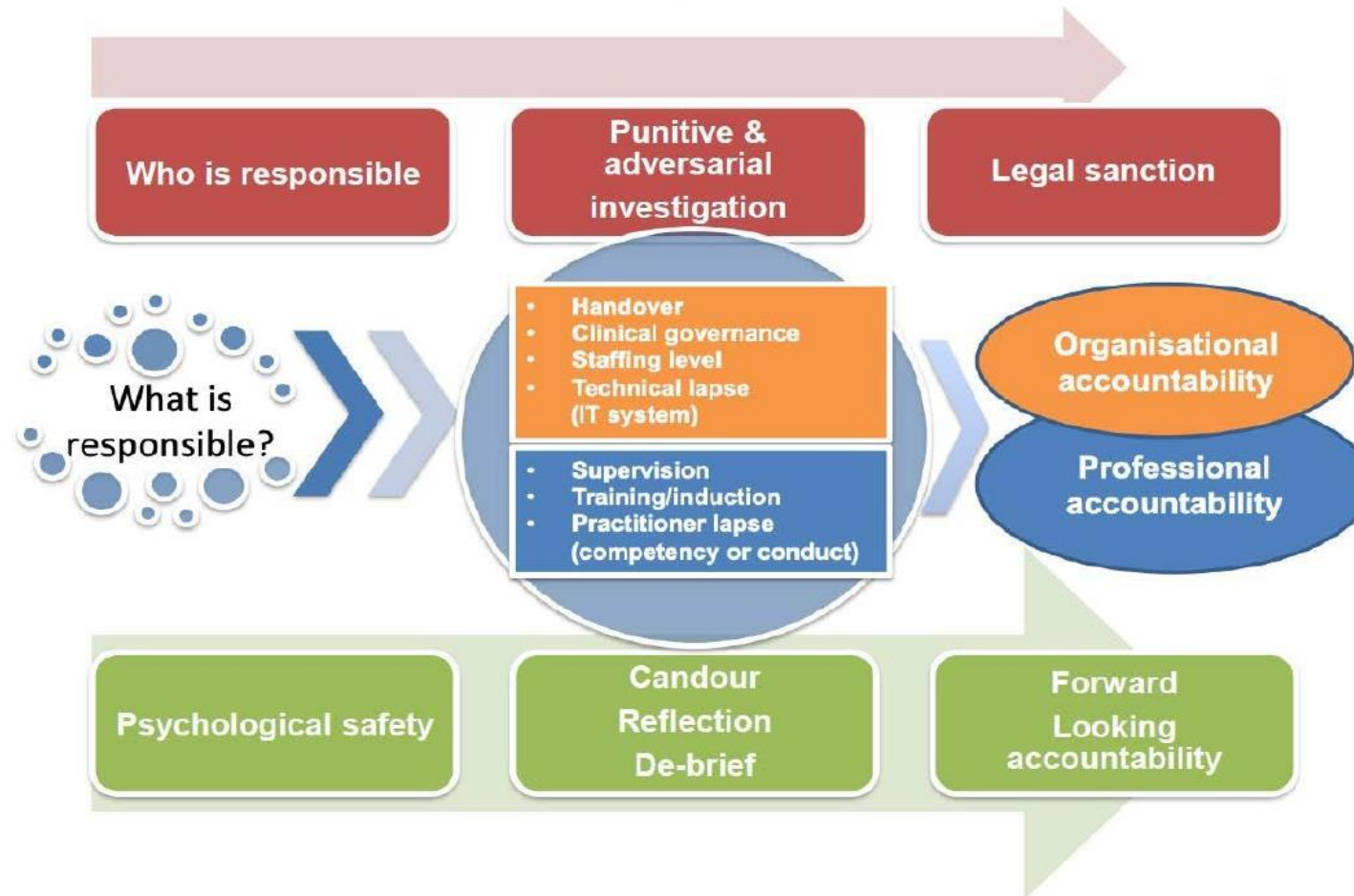
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User experience

Design

4. Distinguish between Causality vs Contribution



5. Systematising Change

Learning from the every day routine, not just incidents



6. Respect & Civility

Our purpose

Respect

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



Our objectives

- 1 Raise awareness and empower staff to challenge poor behaviour and choose respect, reinforcing civility and positive culture.
- 2 To develop a comprehensive training programme to enhance emotional intelligence as to how behaviours can be perceived and received.
- 3 Triangulate data sources to measure and evaluate impact.

The #IWillSpeakUp campaign encourages bystanders to feel supported to ‘speak up’ if they see poor behaviour. This campaign has had a direct correlation on our staff survey results.

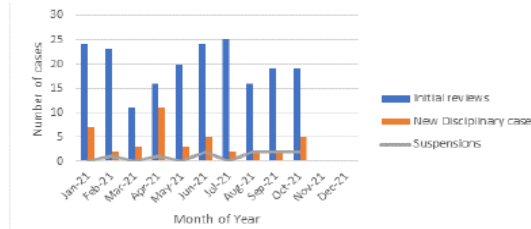


		MCT 2021/22	MCT 2020/21	MCT National Rank*	All MH / LD/Community Trusts 2020/21	MCT North West Rank	Comparison with 2021/22 National Combined MH / LD and Community Trusts
14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	High Good	64.7%	66.8%	7th	6th	2nd	Better than National Average

*Out of 217 Trusts

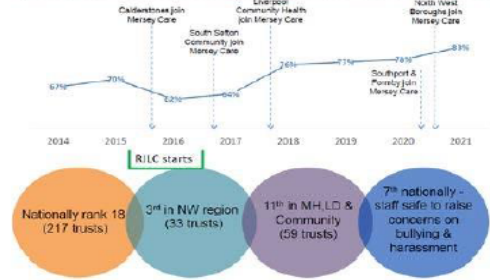
What the data tells us.

Initial reviews, new disciplinary cases & Suspensions



Staff feel safer in raising concerns

Question: I would feel secure raising concerns about unsafe clinical practice



Benefits

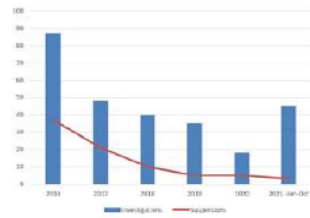
People process – investigations decreased by 89% over last 6 years, and suspensions by 91%

National performance measures improved from achieved from 56% to 92% over last 3 years

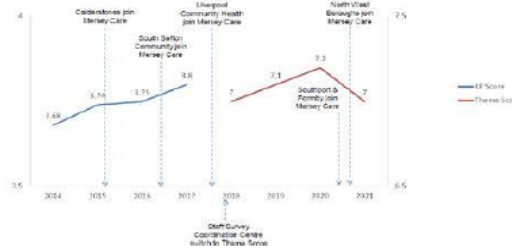
Sustain staff survey metrics and improving in patient and staff safety measures even during pandemic and post acquisitions

Investigations and Suspensions

- Investigation have decreased by 48% from 2016
- Suspensions have decreased by 91% from 2016
- At the same time the Trust has increased its workforce by 221%



Trust Staff Engagement Scores



Benefits



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For the Trust

We have focused compassionate HR and patient safety systems and processes;
Seeing our people as the solution and not the problem;

Shift in judgemental language;

Culture that allows the boss to hear bad news;

Co-produced approach with staff, unions, ambassadors and patients/users;

See transparency and openness as allies not enemies;

Sharing good practice stories (lessons, confessions, gratitude)

Trickle down of restorative culture in everyday organisational life

We are all human – show it

To create the best safety culture, staff have to feel safe themselves



For YOU, our Workforce

Acceptance we are not always on our 'A' game

Even the best employees will have blips

Safe to raise a concern

Culture that allows the boss to hear bad news

Empowered to catch errors

Accountable but not punished for human errors

Learn when things go well and when they cause harm

Asking 'what' and 'why' instead of 'who' will drive learning and improvement



For Patients

All staff protect our values by the choices they make every day in doing their job

Accountable staff

Reduce risky behaviour – catch errors before they occur to minimize or prevent errors of the future

Reckless behaviour is not accepted by anyone

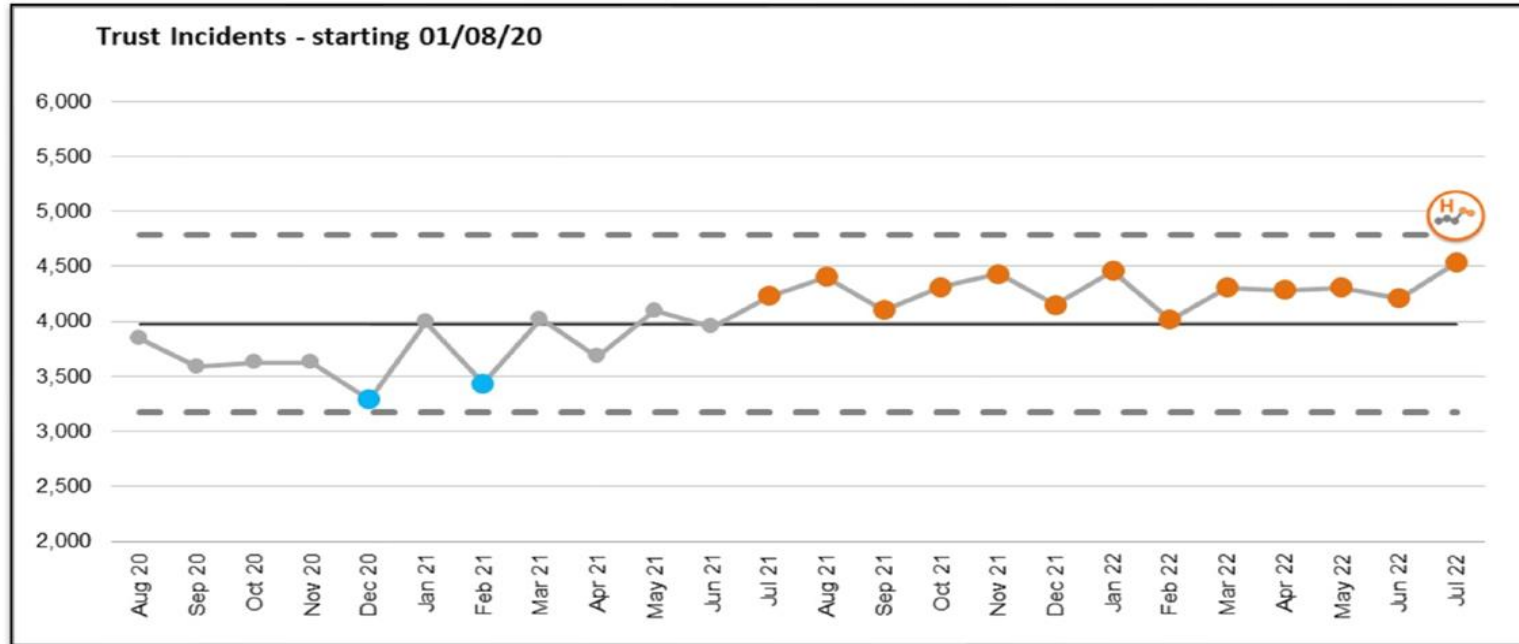
Staff morale is high as staff are empowered to do the best job they can do

Total Incidents August 2020 to July 2022



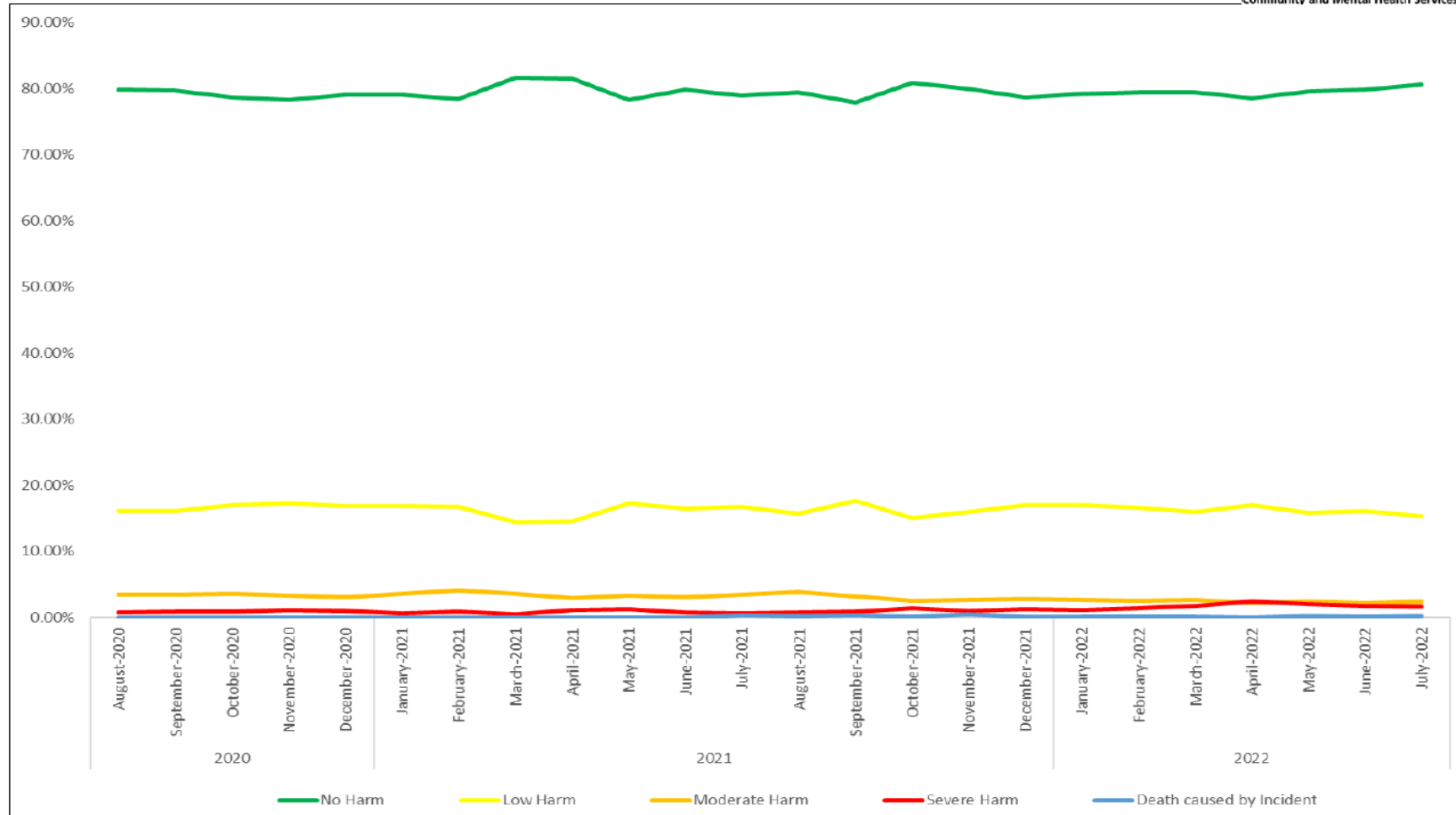
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Total Incidents broken down by levels harm August 2020 to July 2022

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Summary

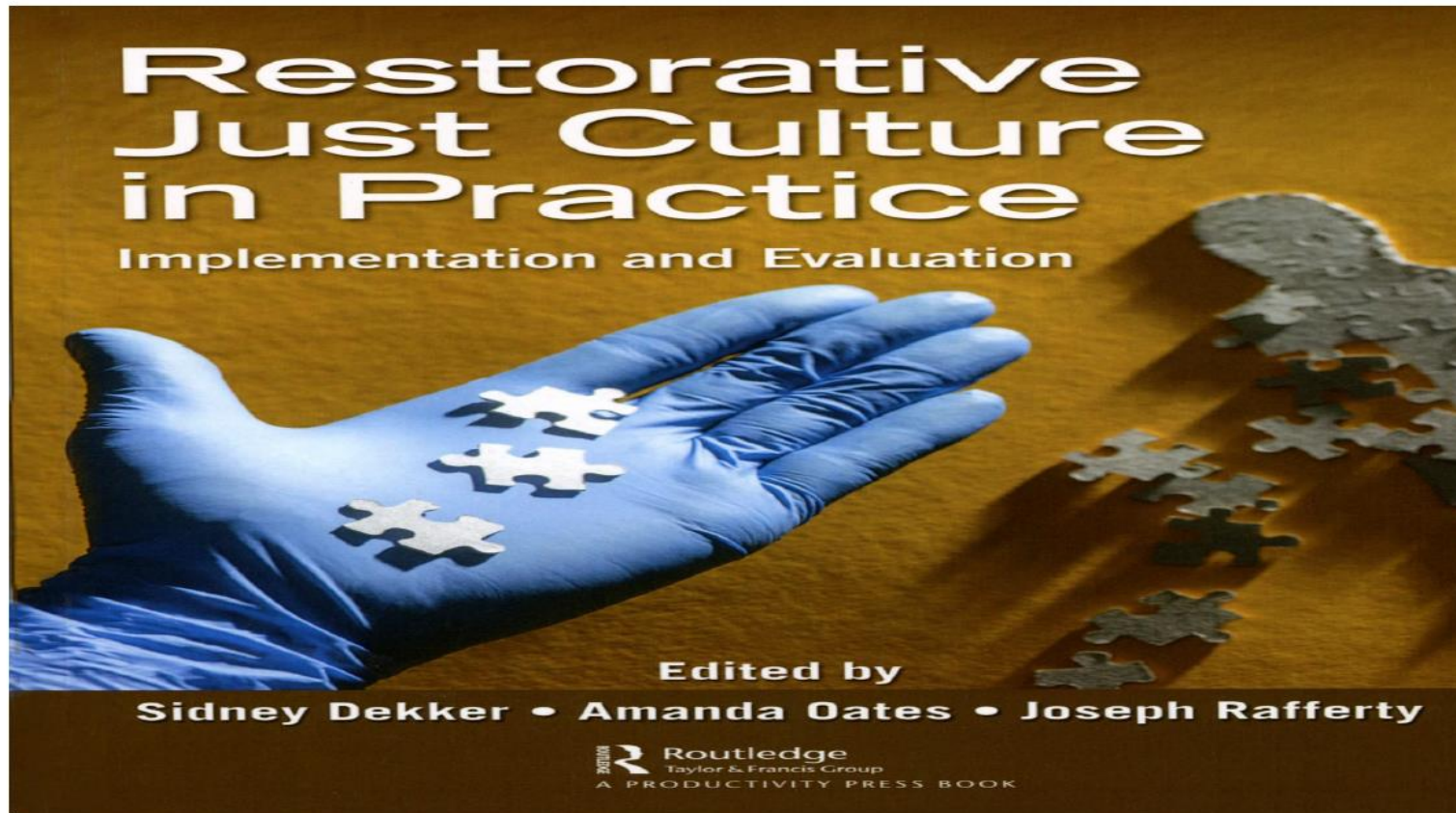


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- We have focused on concept into practice
- Culture that allows the boss to hear bad news
- Co-produced approach with staff side
- Moving to learning from our routine work
- See your people as the solution and not the problem
- Sharing your vulnerability

Thank you for coming



TWITTER

@JR_MerseyCare

@amandajoyoates

CONNECTING PEOPLE INTERESTED IN QUALITY AND PATIENT SAFETY

<https://www.hse.ie/eng/about/who/nqpsd/>

@QPSTalktime

@NationalQPS

#QIreland



HEARING YOUR THOUGHTS AND COMMENTS

“Restorative Just Culture”- Resources

- HSE Just Culture Guide & Assessment Framework
 - <https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/just-culture.html>
- Just Culture Movie (produced by Sydney Dekker)
 - <https://safetydifferently.com/just-culture-the-movie/>
- Mersey Care e-learning packages
 - <https://www.mersecare.nhs.uk/about-us/restorative-just-and-learning-culture>

Walk and Talk Improvement: Ideas for Safe Quality Care

Purpose

- Improve patient care by capturing the personal stories of people who work in and use health services regarding patient safety and quality improvement using a new and increasingly popular communication platform.
- Co-produced with patient partners, and members of the the Health and Social Care Quality Improvement (HSCQI), Northern Ireland and National Quality and Patient Safety Directorate (NQPSD) teams.
- 6 episodes based on the Patient Safety Strategy themes.

Where to listen?

Acast!



*Also available on
Spotify podcasts*

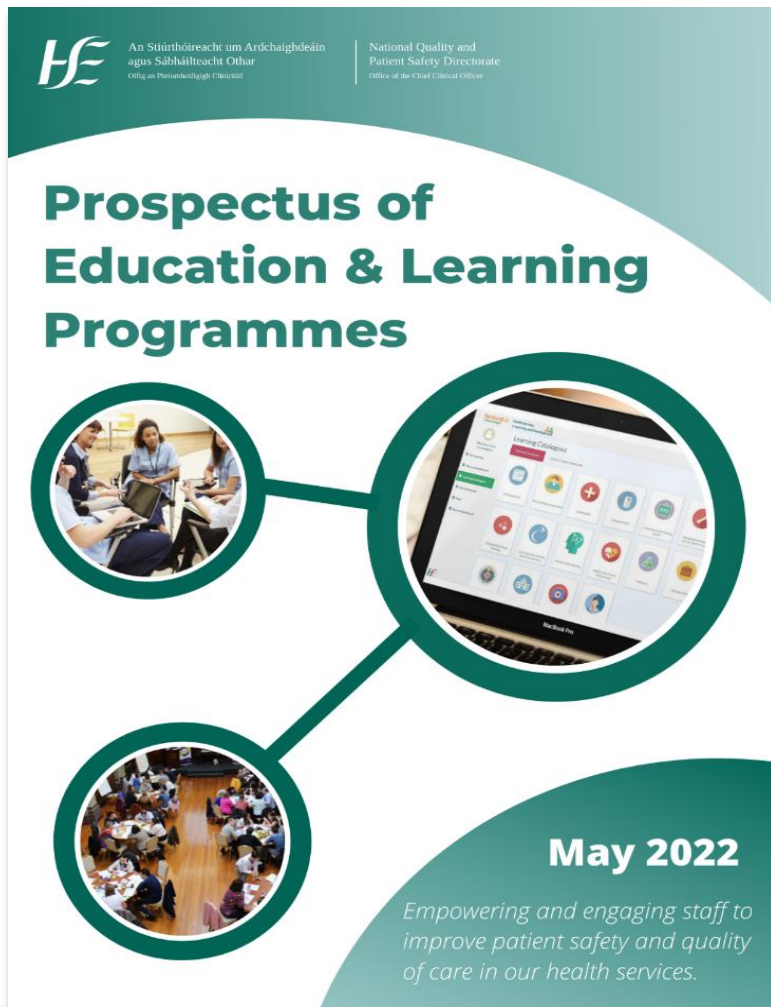


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<https://www.hse.ie/eng/about/who/nqpsd/qps-education/prospectus-of-education-and-learning-programmes.html>



NATIONAL
OPEN DISCLOSURE
PROGRAMME

hseland.ie
Cúram le Eolas

Module 1

Communicating Effectively through Open Disclosure

Module 2 Open Disclosure - Applying Principles to Practice

Open Disclosure Face to Face **Skills Training**

Open Disclosure **Train-the-Trainer** Programme

Open Disclosure **Webinar** Programme

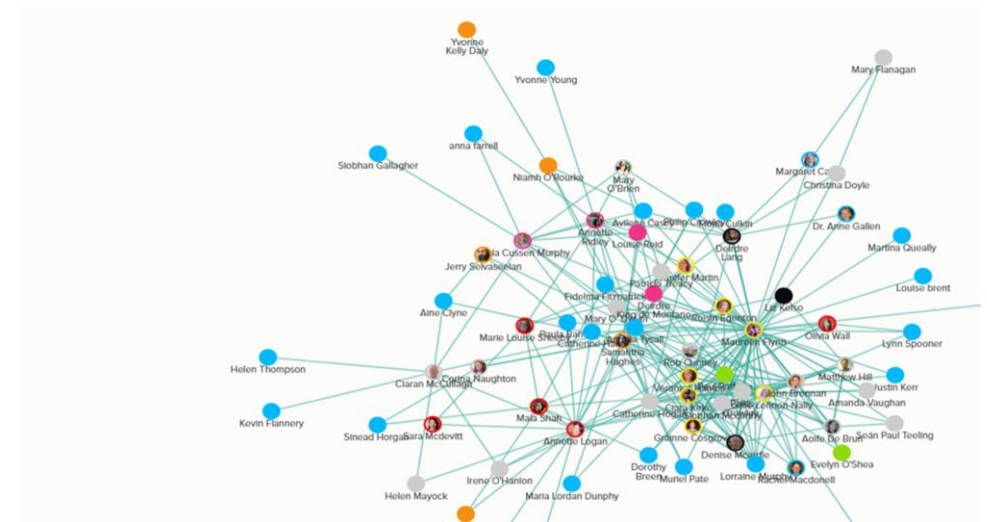


The QPS Ireland Network Map

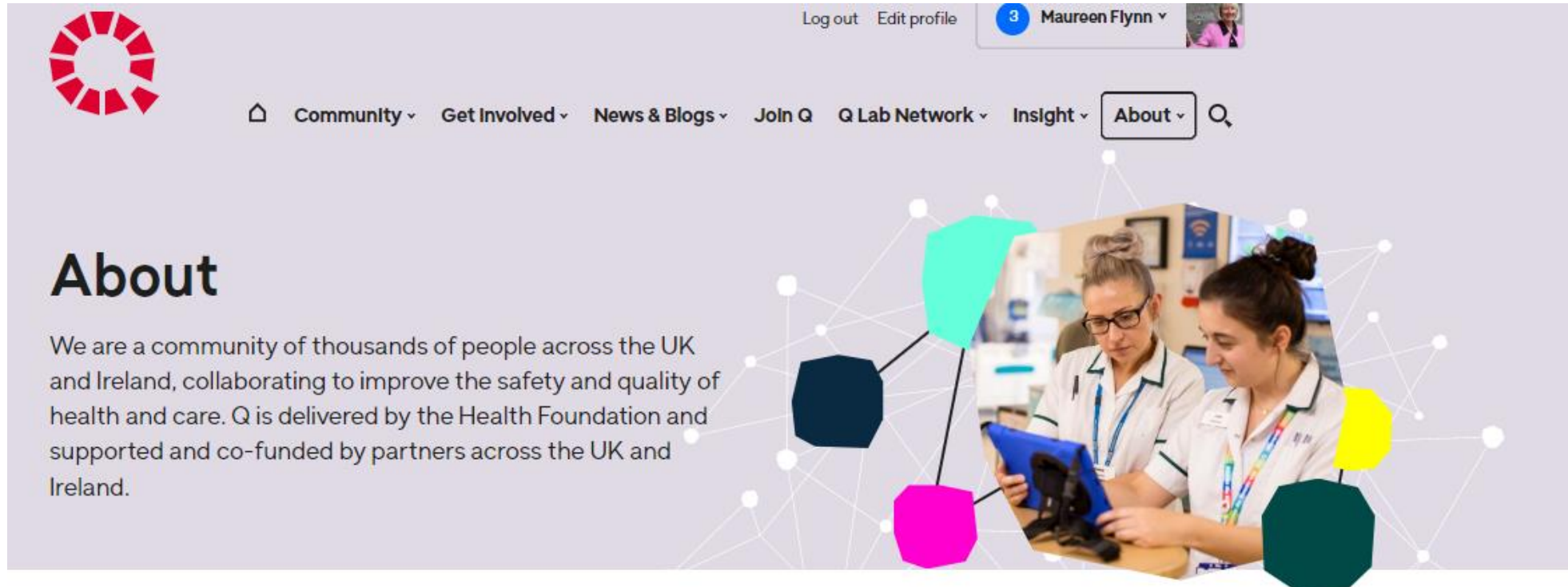
To help visualise connections between people interested in quality, safety and improvement across Ireland: <https://www.hse.ie/eng/about/who/nqpsd/qps-connect/network-map/>



- How to join the map?
 - Visit the HSE website (see link in the chat)
 - Get sent your unique link to the map
 - Enter information about you, your professional characteristics and your interests
 - Log your connections
- How to use the map?
 - Filter the map by role, organisation, interests
 - View individual profiles
 - Connect and collaborate with others



Apply to become a member of Q Community



- All you need to know about applying can be found on the Q website
- You will be invited to complete an online application using the Q online portal
- If you have queries or require support, please contact our colleague via email

Caroline.Lennonally@hse.ie

Upcoming Webinars: Dates for your diary

Dates	Topics	Speakers
Thursday 6 th October 12:45 – 13:30	IADNAM Conference: Effective Communication When Time is Tight and The Stakes Are High Supporting Quality and Patient Safety	Cathy MacDonald, Hostage and Crisis Negotiator Advisor and Communication practitioner
Tuesday 11 th October 13:00 – 13:55	Live from National Patient Safety Office Conference 2022 Dublin Castle	Maurice O'Donnell, Head of Patient Safety Legislation and Advocacy Prof. Suzette Woodward, Patient Safety Advisor Louise Loughlin, National Advocacy Service for People with Disabilities Dr. Natasha Rafter and Lorraine Schwanberg

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<https://www.hse.ie/eng/about/who/nqpsd/qps-connect/qps-talktime/qps-talktime.html>



Let us know how we did today

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS Talktime Webinars by sharing your feedback

We really appreciate your time, thank you

Contact: Stephen.Barrett@hse.ie to be included on our mailing list to receive QPS Talktime invitations



*Thank
you*