AGENDA ITEM
(5.3)

PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE

A JUST AND LEARNING CULTURE
The balance of fairness, justice, learning and taking responsibility for actions

Date of meeting	28/10/2020
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Approving Executive Sponsor	Executive Director of Workforce & Organisational Development
Report purpose	ENDORSE FOR COMMITTEE APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Local Partnership Forum	15/09/20	SUPPORTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 What is a "Just and Learning Culture"?

The Mersey Care NHS Trust developed the "Just and Learning Culture" phrase and the associated methodology to:

"*Create an environment where the Trust places an equal emphasis on accountability and learning. It is a culture that instinctively asks in the case of an adverse event, "what was responsible, not who is responsible". It is neither finger-pointing nor blame-seeking. It is also not an uncritically tolerant culture in which anything goes*".

In June 2019, Professor Sir Norman Williams was commissioned to set up and conduct a rapid policy review into the issues relating to gross negligence manslaughter in healthcare.

Professor Williams concluded in his findings:

"*A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution*".

The report findings also stated;

"*…generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts*".

Professor Williams' findings reinforce that to avoid harm to patients, NHS organisation need to adopt a just and learning culture.

1.2 Mersey Care NHS Trust's Just and Learning Culture

The concept of a "Just and Learning Culture" was developed by Mersey Care NHS Trust in 2016, in response to concerns raised by trade union colleagues in respect of the very high number of suspensions and disciplinary cases relating to patient safety incidents. Further research by the Trust found that staff were reluctant and lacked the confidence

to speak up when things went wrong, because they feared the associated consequences of blame.

Consequently, there was a realisation that valuable lessons were not being learned which could be resulting in the same errors and incidents being repeated. In response, the Trust began working in partnership with their trade unions and stakeholders to establish an alternative approach.

In researching alternative approaches, the Trust acquired learning from other high risk industries such as airlines, nuclear energy, oil and exploration and some healthcare providers in the US, along with the "Just Culture" academic work developed by Professor Sidney Dekker. The research findings inspired the Trust to develop a zero blame culture that would provide staff with a safe place to work and one where they would be treated fairly and with compassion.

This led to the development of a just and learning culture, to provide all stakeholders with a more realistic understanding of the risks, the needs of staff and the organisation's expectation of learning, when things did not "go as expected". The Trust understood the importance of language to help change and embed the new culture. It therefore made a deliberate decision to avoid language inferring that something had gone "wrong".

The approach adopted by the Trust is based on the principles of restorative justice, which aims to repair trust and relationships damaged after an incident. This approach allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm. Their approach therefore emphasizes:

- Working with trade union colleagues in partnership;
- The importance of language to change and embed the new culture. They deliberately to avoid language inferring that something had gone "wrong";
- The risk of hindsight bias (the tendency of individuals to overestimate their ability to have predicted an outcome that could not possibly have been predicted);
- A change of focus from policies that punish to policies that assist good practice;
- A focus on informal approaches over formal procedures;
- A fair balance of justice, forward looking accountability and intervention;
- Ensuring that staff feel it is safe to speak up, with specific mechanisms to support this;
- The importance of sharing learning, anonymised if required;

- A regular refresh of the Trust's values and drawing on human factors science; and
- The introduction of a new value of support, which included encouragement to raise concerns to enable learning from experience.

1.3 The Impact of the implementation of a Just and Learning Culture within Mersey Care NHS Trust

In 2014, the Trust employed 3500 staff and had 143 live and ongoing disciplinary investigations.

Since the introduction of their just and learning culture in 2016, there has been a notable decrease in the number of disciplinary cases. In the pilot and launch year, 2016 / 2017, there was a 54 per cent reduction in disciplinary investigations across their two clinical divisions, saving the Trust £1.7m in clinical suspensions.

In 2018 / 2019, the Trust employed 8000 staff and had only 28 disciplinary cases. They also saw a significant decrease in the number of staff suspensions, which went down from 55 to five in the same period.

The national staff survey also showed corresponding increases in staff engagement and motivation since the introduction of the just and learning culture. In response to the NHS staff survey question "My organisation treats staff who are involved in an error, near miss or incident fairly", staff responses increased from 45.9 per cent in 2017, to 55 per cent in 2018.

Despite these early successes, the Trust continues to strive to reduce the number of disciplinary cases and suspensions, as they believe the current numbers are still too high and can and should be further reduced. They recognise that in each of these cases, there can be harm or potential harm to patients, stress, anxiety and upset for the staff member involved, their team and also their families.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Independent Review Report into CTMUHB Maternity Services

The independent review report into concerns relating to maternity services, within the former Cwm Taf University Health Board, resulted in the NHS Delivery Unit being requested to work with the Health Board. The NHS Delivery Unit's role is to ensure that there are effective

arrangements in place for reporting, managing and reviewing patient safety incidents and concerns.

The promotion and embedding of a just and learning culture would assist the Health Board to put in place a new intervention that would assist the organisation to review, appropriately manage, respond and learn from all future patient safety incidents and concerns.

2.2 Why should the Health Board promote and embed a Just and Learning Culture?

It is recommended that Cwm Taf Morgannwg University Health Board promotes and embed a just and learning culture to assist the organisation to operate the safest and most transparent working environment possible.

Currently within the Health Board, too often the approach taken when dealing with risk still places an emphasis on the problems that instigated an incident and the people or person involved, rather than the solutions to rectify the problems encountered.

The promotion and embedding of a just and learning culture would:

- support a climate of openness and transparency;
- encourage staff to feel confident to speak up when things do not go as expected, rather than fearing blame;
- use language that is restorative rather than punitive, removing the fear of blame;
- recognise that there are several reasons why things may not go as expected e.g. system issues, policy, training, environmental or human factors and identify the relevant factor(s).
- Build trust with staff;
- Improve staff morale;
- ensure that all of staff are treated fairly and with compassion;
- maximise the opportunities to learn from adverse incidents; and
- support continual improvements by assisting the organisation to do things better and safely for the benefit of our patients and service users.

2.3 How does a Just and Learning Culture fit with the Health Board's Values and Behavours?

On the 29 June 2020, the CTMUHB Board approved the new Values and Behaviours Framework. While the Framework does not make

specific reference to a "Just and Learning Culture", the approved values and behaviours are aligned to the aims and will promote a work environment where this culture can flourish i.e.

- We Listen, learn and improve;
- We Treat everyone with respect; and
- We work together as one team.

Therefore, now is an opportunistic time to start to promote and embed a just and learning culture, as part of the wider values and behaviours work being undertaken across the Health Board (**Appendix A**).

2.4 How to Promote and Embed a Just and Learning Culture

It is proposed that the Health Board will promote and embed a just and learning culture based on the best practice work undertaken by Mersey Care NHS Trust, the NHS (England) "Improvement Guide" (developed to promote cultural change to avoid a blame culture) and the NHS Resolution "Being Fair – Supporting a Just and Learning Culture for Staff and patients following Incidents in the NHS" guidance.

The following actions will need to be undertaken and implemented if the Health Board is serious about realizing this cultural shift:

- Develop a Health Board "Just and Learning Culture Charter", which will set out the roles and responsibilities of staff and manager; how the organisation will deal with patient safety incidents when things do not go as expected and how staff will be treated and supported in the event of such an incident.

- Develop a "Just and Learning Culture Guide for Health Board Managers and Staff" which communicates and explains the approach that will be taken when responding to an incident.

The guide would also provide a tool to assist staff, patients and their families to understand how the appropriate response to a member of staff involved in an incident, can and should differ, according to the circumstances in which an error was made.

The guide would confirm and reinforce that the Health Board's just and learning culture process i.e. it:

- would not replace the investigation of a patient safety incident, as only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents;
- could be used at any stage of an investigation, as the guide may need to be revisited as more information becomes available;
- would not replace HR advice and should be used in conjunction with relevant Health Board HR and Organisational policies; and
- could only be used to review and consider one action (or failure to act) at a time. Where multiple actions were involved in an incident they would be required to be considered separately, using the guide.

The guide would clarify and confirm how it inter-links with and should be utilized alongside the NHS Wales Disciplinary Policy (all non-medical staff) and the Upholding Professional Standards in Wales Policy (all medical and dental staff).

N.B. The Health Board utilizes the NHS Wales Disciplinary Policy and the Upholding professional Standards in Wales Policy, which are NHS Wales approved, standard policy documents. As only the Welsh Partnership Form can agree changes to these policies, the Health Board will have to seek permission to insert a reference to our just and learning culture and a link to the guide for managers and staff. If such permission cannot be obtained the "Just and Learning Culture Guide" will become a stand-alone document for managers and staff will be that will form an appendix to the NHS Wales Policy.

- Develop an additional process to support and underpin the currently disciplinary initial assessment process and documentation that supports the conversation between the manager and their staff about whether their involvement in a patient safety incident requires specific individual support, an intervention to enable them to work safely or formal disciplinary action.

  The process would require managers to apply and ask the following key test principles and questions, to assist them to fully and fairly assess and consider the circumstances, before any decision, including formal management action was taken in respect of the staff member i.e.

  1. Deliberate harm test
  - Was there any intention to harm?

2. Health test

- Are there any indications of substance misuse?
- Are there any indications of physical ill health?
- Are there any indications of mental ill health?

3. Foresight Test

- Are there agreed protocols/accepted practice in place that apply to the action/omission in question?
- Were the protocols/accepted practice workable and in routine use?
- Did the individual knowingly depart from these protocols?

4. Substitution Test

- Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?
- Was the individual missed out when relevant training was provided to their peer group?
- Did more senior members of the team fail to provide supervision that normally should be provided?

5. Mitigation Test

- Were there any significant mitigating circumstances?

By requiring the manager to ask and explore the above series of questions, it would assist them to clarify whether there truly was something specific about the staff member that needed support or management, versus whether the issue was wider, in which case singling them out would be unfair and counter-productive.

The structured questioning approach will also help to reduce the role of unconscious bias when managers are making decisions and ensure that all staff regardless of their staff group, profession, pay band / grade or protected characteristic(s), are treated equally and fairly.

The Health Board would also underpin this process by amending the current disciplinary initial assessment checklist that would focus more on the just and learning culture process and less on the punitive process.

- The approved guide would be cross referenced in all relevant Organisational HR, incident reporting and any other relevant policies

and procedures, to ensure a fair and consistence approach is taken in response to patient safety related incidents. This will require the workforce function to work in partnership with stakeholder (trade union colleagues and functional leads) to review and update relevant policies and training packages, to incorporate the just and learning culture considerations and requirements.

- Develop just and learning culture training for managers and trade union colleagues based on the Health Board guide.

- Develop awareness raising events for managers and staff.

- Encourage managers and staff to self-nominate to become "Staff and Trade Union Just and Learning Ambassadors", to work across the Health Board to drive the necessary cultural changes. The role and work of these ambassadors would be directed by the People and Culture Committee.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The promotion and embedding of the new cultural approach over time will provide staff with improved confidence to speak up when things do not go as expected, because they will have assurance that the Health Board will investigate "what happened" and not "who" was to blame, allowing valuable lessons to be learnt and appropriate support provided and action taken.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The just and learning culture approach will create an open and honest environment when an incident or error occurs. In this culture the organisation's first question will be "what *happened?"* instead of "*who is responsible?"* to facilitate learning and improvement in patient and staff care and experience. Working in this type of culture also has a positive impact on staff morale, through the reduction in formal HR employment

	relations interventions such as disciplinary cases.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Staff and Resources Staying Healthy Safe Care Dignified Care Effective Care
Equality impact assessment completed	No (Include further detail below)
	Equality Impact Assessments would be undertaken in respect of just and learning Culture related policies, processes and guidance.
Legal implications / impact	Yes (Include further detail below)
	Reduce the number of future potential employment Tribunal Claims
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	It could reduce the costs associated with staff suspensions, internal disciplinary processes and future Employment Tribunal legal costs and compensation claims.
Link to Strategic Well-being Objectives	Co-create with staff and partners a learning and growing culture

5. RECOMMENDATION

5.1 It is recommended that the People and Culture Committee **ENDORSES for APPROVAL** the report recommendation, to promote and embed a just and learning culture across the Cwm Taf Morgannwg University Health Board.

5.2 The People and Culture Committee is asked to **NOTE** that this work will be progressed alongside the implementation of the Health Board's Values and Behaviours Framework.

(Appendix A)

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD APPROVED VALUES AND BEHAVIOURS

Value	Behaviours
3. We listen, learn and improve	• We take time to ask and listen carefully to people's worries, views and ideas — then actively do something to make a difference. • We make it safe and easy for people to speak up - as well as being open to giving and receiving feedback as a chance to learn. • We welcome change, bring a positive, 'will do' attitude and find ways to actively improve the way we do things.
4. We treat everyone with respect	• To show that we value other people and see them as equals, we treat everybody with kindness and fairness. • We go out of our way to be supportive, helpful and friendly. • We recognise what people do every day to make a difference, and say 'thank you'.
5. We all work together as one team	• We bring people together and build strong, trusting relationships by including others in decisions and activities. • We look out for people's wellbeing and safety — both physical and psychological — and support them if these are at risk. • We are open, clear and honest in the way we communicate, and — if we need to — change the way we explain something to help people understand. • When we learn something useful and inspiring, we share it with others.