JUST CULTURE IN HEALTHCARE: THE DAWN OF A NEW ERA

Healthcare is starting to embrace a shift towards Just Culture. In England, the new Patient Safety Incident Response Framework prioritises respect, compassion, and systemic improvements. The potential benefits of this, and other initiatives, are significant, as **Suzette Woodward** reports.

KEY POINTS

- **Healthcare has faced increased complexity and workload, along with limited resources, decreased morale, and an increase in incivility and bullying.**
- **The Patient Safety Incident Response Framework (PSIRF) has been introduced in the NHS in England, emphasising a shift towards compassionate engagement and system-based learning.**
- **The PSIRF is supported by a toolkit, training for all NHS staff, and guidance on involving patients, families, and staff following an incident. The guidance outlines principles aligned with a Just Culture, including meaningful apologies, respect, compassion, collaboration, and equity.**
- **Other healthcare initiatives are increasingly focusing on restorative Just Culture.**

"The easy, understandable and completely wrong answer to an incident is to blame those who made the mistake." This quote was written in the editorial of the British Medical Journal, published in March 2000 – 23 years ago. The editorial was written by two paediatricians (Lucian Leape and Don Berwick) who described the need for a 'movement' that raises awareness of the fact that staff need help to function under adverse conditions, including pressures of time, fatigue, or high anxiety.

Fast forward two decades later, and healthcare has experienced significantly increased complexity and workload, while struggling with low staffing levels and limited resources. Additionally, the pandemic has led to decreased morale and more staff leaving the service. To make things worse, there has been an increase in incivility and bullying.

In healthcare, like other complex sectors, safety is a consequence of adapting and adjusting to demand and frequent changes. Staff are constantly dealing with unexpected situations and trying to detect and correct when something is about to go wrong. We need to help staff cope with this complexity under pressure and help them achieve success despite the fallible, imperfect systems, unrealistic rules, and sometimes incompatible policies. Given this context, it is vital that we build a Just Culture so that when the inevitable happens, people are treated fairly, consistently, and proportionately.

The Patient Safety Incident Response Framework

To achieve this, a variety of interventions are being used across the NHS in England to influence behaviour and culture. Setting the tone is the new national framework to respond to incidents and accidents, the Patient Safety Incident Response Framework (PSIRF) (see https://www.england.nhs.uk/patient-safety/incident-response-framework/). This has been tested across some early adopter sites and now, in 2023, has been disseminated to all healthcare organisations in England.

The PSIRF supports integrates four key aims:

1. compassionate engagement and involvement of those affected by patient safety incidents
2. application of a range of system-based approached to learning from patient safety incidents
3. considered and proportionate responses to patient safety incidents, and
4. supportive oversight focused on strengthening response system functioning and improvement.

The PSIRF sets out the NHS's new approach to studying systems and processes in response to patient safety incidents for the purpose of learning and improving patient safety. It shifts away from the focus on individuals to the systems that individuals are working within. It replaces the serious incident

framework and even removes the classification 'serious incidents' from the nomenclature.

The PSIRF is a fundamental change in how the NHS responds to patient safety incidents and advocates a co-ordinated and data-driven approach. It promotes compassionate engagement with all those affected by patient safety incidents. It also suggests moving away from the use of so-called 'root cause analysis', preferring models such as after-action review (AAR) and the systems engineering initiative for patient safety (SEIPS). This approach prompts a significant cultural shift towards systematic patient safety management and a Just Culture.

All NHS staff will receive training over the coming year. The training must cover Just Culture, being open, apologising, effective communication, and involvement. In addition, organisations are asked to set up support systems and develop resources for staff and patients.

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The PSIRF has been supported by a toolkit to support implementation and guidance on involving patients, families and staff following an incident. The guidance sets out nine principles that are clearly aligned to a Just Culture:

1. providing meaningful apologies to all involved
2. ensuring an individualised approach to patients and staff
3. being sensitive to what people need and when
4. treating those affected with respect and compassion
5. ensuring all guidance is clear
6. listening to all affected and providing the opportunity for people to share their experience
7. being collaborative and open
8. accepting that there will be subjectivity as everyone will experience the same incident in different ways, and
9. striving for equity.

How will we know all of this is working? Researchers from the University of Leeds are leading a project called the Response Study. The Response Study is a real-time independent evaluation of the implementation of PSIRF across the NHS in England. The project is funded by the National Institute for Health and Care Research. The study started in May 2022 and will conclude in 2025.

'Being Fair'

In healthcare safety, there are countless issues that deserve our attention. As well as safety, there are issues of sustainability, efficiency, effectiveness, equality, diversity and inclusivity, staff wellbeing, and psychological safety. The drive for a Just Culture could get lost in all this activity. So national and regional organisations are collaborating to support this change programme. For example, NHS Resolution (the body that is responsible for paying negligence claims in the NHS)

has published its second edition of 'Being Fair'. This sets out the links between culture, workforce and patient safety. NHS Resolution has a *Just and Learning Culture* Charter that NHS organisations are invited to adopt. Additionally, there is increasing alignment between those working in safety and those working in organisational development and human resources. Many healthcare organisations have updated their disciplinary policies to incorporate the principles of a Just Culture.

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The Civility and Respect Toolkit

NHS Leadership has also developed a toolkit to promote cultures of civility and respect. One of the four themes of the toolkit is a 'just and restorative culture'. This focuses on 'compassionate leadership', and emphasises working with partners such as local union representatives, 'Freedom to Speak Up Guardians', and those who lead work on employee engagement, and health and wellbeing.

Towards a Restorative Approach to a Just Culture

The current healthcare culture not only tends to blame and shame, it is also often both adversarial and retributive. There is now a move towards a restorative approach to a Just Culture. Some healthcare organisations are testing how to achieve a restorative approach to help repair relationships. In the NHS in England, one community and mental health organisation is at the forefront of this work. Mersey Care NHS Trust is working in conjunction with Northumbria University to deliver a five-day course on the principles and practices of restorative Just Culture.

Conclusion

The Patient Safety Incident Response Framework is a renewed focus on moving away from a blame culture to one that is just and compassionate, recognising wider systemic problems. It provides NHS organisations with the freedom to target resources on investigations that will lead to organisational learning and improvements. However, implementation will be challenging in the current climate of an exhausted and reduced workforce with limited time for staff to attend training. But the potential advantages for patients, families, and staff are substantial. We might finally have the movement that Leape and Berwick talked about all those years ago.

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