A just culture guide

Thinking Differently to Improve Flow

The Midland, Manchester
18 September 2018
Exercise

J Bloggs
Outcome of our exercise
Rasmussen’s Skill, Rule and Knowledge model

- **Novel task:** Learning rules and rehearsing routines
- **Automatic, familiar & well practiced routines:** Consciou s Thought
- **Skill:** Knowledge
A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents
‘A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution’.

‘…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’.

Norman Williams’ Gross Negligence in Manslaughter report June
A reporting and learning culture revolution

Some key priorities for the national patient safety team:

- NRLS Launched
- Incident Decision Tree Implemented
- Being Open Published
- National Framework for Reporting and Learning from Serious Incidents Published
- DPSIMS Scheduled for 2019
- A just culture guide Published March 2018
- Duty of Candour Published 2015
- Serious Incident Engagement Programme Launched March 2019
‘A’ just culture guide—putting it into national context

Aligning with national just culture initiatives

• Professor Sir Norman Williams review
• Dame Clare Marx on the GMC commissioned review of gross negligence manslaughter
• Endorsed by NHS Wales; Scotland exploring endorsement
• DHSC interest in just culture as part of workforce priority

Aligning with partners

• Embedded in regulator guidance
• Increasingly championed by Royal Colleges and trade unions
ERROR TYPES – based on the work of James Reason

Rule-based mistake = Following-the-wrong-rule
Knowledge-based mistake = Not-having-the-knowledge
Violation = Knowingly breaking a rule

Intended actions

Mistakes

Rule based errors
Routine Reasoned
Reckless Malicious

Knowledge based errors

Skill based errors
Memory or attention failures

Unintended actions

Slips & Lapses

Unsafe acts
What we changed, how, and why

• Our evaluation highlighted how technical safety or human factors terms were commonly misinterpreted. e.g. ‘unacceptable risk’; ‘systems’

• Iterative testing of changes with frontline users

• Eliminating redundant steps from the original model and simplifying the flow

• Updated and future proofed recommendations
Formally endorsed by...

Supported by many more
Group work: training scenarios available

Scenarios based on real incidents (combined, fictionalised) and shaped towards what the NHS told us was most challenging:

• Not just clinical staff close to the incident but actions by others in the weeks or months before

• Linking back to organisational systems for safety that should have been in place

• Expecting old heads on young shoulders

• Staff who are not ‘bad’ but are not like their peers in terms of ability to acquire knowledge and skills or atypical in their attitude

• Misplaced focus on consequence, not behaviour

• Repentance ≠ certainty it won’t happen again

• Teams/units with a different custom and practice
Where to start? Lessons from early adopters

A pathway to implementation

Using the video and training scenarios

Embedding in trust training

Reducing focus on individuals

Empowering representatives

Patients and Public Voice

Empowering patients
What’s next on just culture?

If you have members using (or will now use) *A just culture guide*, we want to learn from you!

- How have organisations brought it into use?
- How has it helped (examples appreciated)?
- Can you help us to reach more audiences – do you have communication routes that you’d like us to contribute to?

- *Just culture in Practice*: coming in Autumn
- Next challenge: changing the culture, not simply shifting blame up the line?

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