The Royal Wolverhampton NHS Trust

NHS

Trust Board Report

Meeting Date:	2 June 2014
Title:	Assessing the Patient Safety Culture: a survey of a cross section of nursing and managerial staff
Executive Summary:	Francis 2 recommended the use of a 'cultural barometer' to support the internal health of the relationships between frontline staff and managers. The Manchester Patient Safety Framework (MaPSaF) is just one methodology used by NHS organisations and healthcare teams to assess their progress in developing a safety culture. MaPSaF was used at RWT in a small scale survey to assess the culture of patient safety. The results provide a degree of assurance that the organisation is Proactive – 'We are always on the alert/thinking about patient safety issues that might emerge' and suggests recommendations to improve this further.
Action Requested:	For the Board to receive information on the survey and to consider the recommendations.
Report of:	Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Charlotte Hall, Deputy Chief Nursing Officer
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	Patient Safety Information Group May 2014
Appendices/ **References/** **Background Reading**	Manchester Patient Safety Framework (MaPSaF) Jan 2006 NHS England http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796 Human Factors in Healthcare: A concordat from the National Quality Board Nov 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Assessing the Patient Safety Culture: a survey of a cross section of nursing and managerial staff

1.0 Background

1.1 The Francis report (2013) which was published following the public enquiry into the failings in care at Stafford Hospital has highlighted the need for changes to be made to patient safety in the NHS. The author of the report, Robert Francis QC has suggested that there should be a "cultural barometer" within the NHS whereby the internal health of the relationships between frontline staff and managers can be measured. As a result of the enquiry, the NHS in England continues to focus on patient safety and as a result of Francis, develop a safety culture that is prioritised as a fundamental priority to improve patient safety.

1.2 Culture of an organisation relates to the beliefs, values and attitudes of its staff and the development of the processes which determine how they work and behave together. Achieving a culture of safety requires an understanding of the values, beliefs about what is important and what attitudes and behaviours related to patient safety are expected and appropriate. A 'good' patient safety culture is suggestive of staff consistently and actively looking for potential problems, looking for risks and putting measures or mitigation in place to reduce this risk. If safety is compromised and something goes wrong, the learning from this is used to put things right and prevent recurrence. Conversely a 'poor' safety culture is one where safety is dismissed as unimportant and not a priority.

1.3 The Manchester Patient Safety Framework (MaPSaF) is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture. MaPSaF uses 'dimensions' or questions about patient safety which relate to attitudes, values and behaviours about safety. These are then reflected in day to day working practices, for instance how incidents are investigated, lessons learnt, team behaviour etc.

2.0 Methodology

2.1 Between October 2013 and January 2014, a small survey of 107 staff was conducted at The Royal Wolverhampton NHS Trust, staff at executive, divisional and directorate level were asked to participate in a Patient Safety Culture Survey; the response rate was 69% with responses provided online. The purpose of this was to ask 8 questions called dimensions which are intended to assess the responder's view on safety culture in relation to beliefs, values, attitudes and processes which determine how staff work together. Respondents were asked to answer on two aspects of their work;

The organisation as a whole and

their individual teams

Participating staff included Executive Directors, Senior Managers at sub director level, Clinical Group Managers, Matrons, Ward Sisters/Charge Nurses, Operational Department Practitioners and Advanced Nurse Practitioners. Out of 105 members of staff sent surveys, 76 responded, 5 of these were discarded because they were incomplete, 34 staff did not respond. A total of 71 responses were used providing an overall response rate of 67.6%.

2.2 **The dimensions (questions) asked:**

Q1 Good practice and continuous development
Q2 Priority given to patient safety
Q3 Recording of incidents errors, never events and near misses
Q4 Evaluating incidents, errors, never events and near misses
Q5 Learning from incidents, near misses, never events and errors
Q6 Communication about safety issues
Q7 Staff education and training on safety issues
Q8 Team working

2.3 The respondent was asked to consider a range of 'descriptors' or statements that, in their view best reflect their answer (see below) . The descriptors range from A through to E. A team or organisation can then use this data to rate itself against the responses provided. E supports a mature organisation, **generative**, with a strong culture of safety being integral to cross Trust working at every level and A being at the other end of the spectrum, **pathological**, i.e. 'why bother with safety?'

The descriptors (statements about the safety culture)

A – Pathological - Why do we need to waste our time on patient safety issues? **B – Reactive - We take patient safety seriously and do something when we have an incident.** **C – Bureaucratic - We have systems in place to manage patient safety.** **D – Proactive - We are always on the alert/thinking about patient safety issues that might emerge.** **E – Generative - Managing patient safety is an integral part of everything we do.**

3.0 Responses

For the purposes of this paper the responses have been summarised into two tables that illustrate the responses to questions about the organisation and individual teams. For analysis the results from the survey with the highest % of responses for each question are highlighted in bold and for overall comparison 'highly positive' responses (D and E) have been amalgamated.

3.1 **Responses about the safety culture of the organisation**

Dimension (question) of safety culture	A	B	C	D	E	D&E
1. Good practice and commitment to overall continuous improvement			10%	**49%**	41%	90%
2. Priority given to safety			**43%**	14%	**43%**	57%
3. Recording incidents, NEs, errors, near misses			8%	38%	**54%**	92%
4. Evaluating incidents NEs, errors, near misses			11%	**45%**	44%	89%
5. Learning from incidents NEs, errors, near misses			18%	**51%**	31%	82%
6. Communication about safety issues		6%	15%	**44%**	35%	79%
7. Staff education and training			**41%**	**41%**	18%	59%
8. Team working		21%	23%	**32%**	24%	56%

3.2 Responses about the safety culture **within their teams**

Dimension (question) of safety culture	A	B	C	D	E	D&E
1. Good practice and commitment to overall continuous improvement			8%	**78%**	14%	92%
2. Priority given to safety		2%	11%	**53%**	34%	87%
3. Recording incidents, NEs, errors, near misses			9%	**55%**	35%	90%
4. Evaluating incidents NEs, errors, near misses		2%	16%	**64%**	19%	83%
5. Learning from incidents NEs, errors, near misses		2%	23%	**64%**	11%	75%
6. Communication about safety issues		5%	33%	**48%**	14%	62%
7. Staff education and training			39%	**45%**	16%	61%
8. Team working		21%	**27%**	19%	23%	42%

3.3 **Dimensions from E and D** support statements of positivity about the culture of safety in the organisation; 'the organisation demonstrates an increasing maturity in patient safety culture; managing safety is integral to the organisation; staff are on the alert thinking about patient safety and any safety issues that might emerge'.

Dimension C supports the view that staff see the organisation as being bureaucratic, whilst having safety systems in place.

Dimension B suggests a reactionary organisation, patient safety is taken seriously but action is usually only taken taking following an incident but this is a reactionary response to patient safety.

Dimension A shows very low level pathological approach to it, the view being "why should we waste our time on such issues".

3.4 The table below provides the details of the levels and the descriptions applied to them in measuring the culture of the organisation and the healthcare teams.

Level	**Description**
A – Pathological	Why do we need to waste time on patient safety issues?

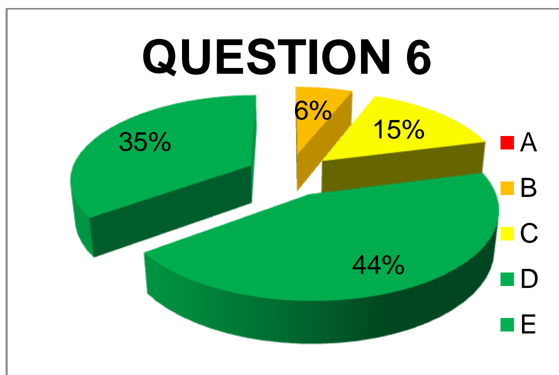
B- Reactive	We take patient safety seriously and do something when we have an accident
C- Bureaucratic	We have systems in place to manage patient safety
D- Proactive	**We are always on the alert/thinking about patient safety issues that might emerge**
E - Generative	Managing patient safety is integral part of everything we do.

4.0 Findings

The narrative around the findings is divided firstly into 'safety culture of the organisation' and 'safety culture of our team' followed by discussion around the overall findings with areas of weakness and strength.

4.1 About the safety culture of the organisation

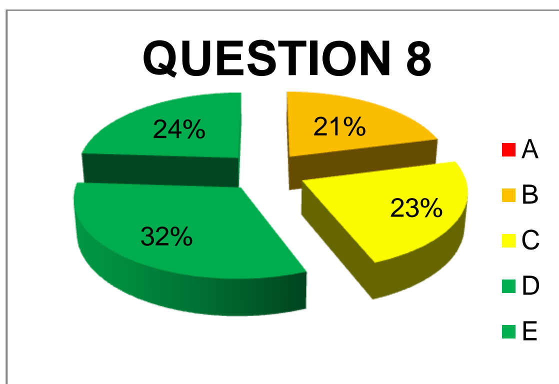
Overall there was a wide spread of descriptors with examples of majority answers in every dimension except A and B. No one responded A to any of the questions which is encouraging. Six out of 8 answers were the majority rating D which supports a view that the **organisation is D - Proactive 'We are always on the alert/thinking about patient safety issues that might emerge'**. Two dimensions had B responses to Question **6** and Question **8** which are weak responses. Despite low numbers of staff stating this, of note is that similar percentages were responded to the same questions in team working.



Q 6 Communication about safety issues

B 6% Amber: Communication is generally about managers giving instructions. Staff are only allowed to talk to a manager when something has happened or gone wrong. Communication is 'as and when'.

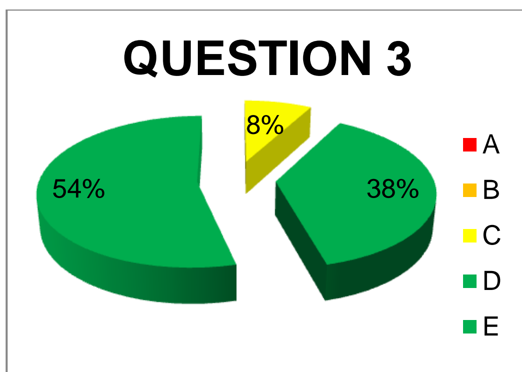
Whilst this is a low % it is key is to acknowledge this



Q8 Team working

B 21% Amber: Although team working is in place throughout the organisation staff members feel concerned that there is not always enough staff and of the impact this could have on incidents or mistakes occurring effecting patient safety. This means staff feel they have to take short cuts or work longer hours and feel the pressure.

4.2 Areas of strength in the organisation



Q3 Handling & recording of incidents, errors, never events and near misses

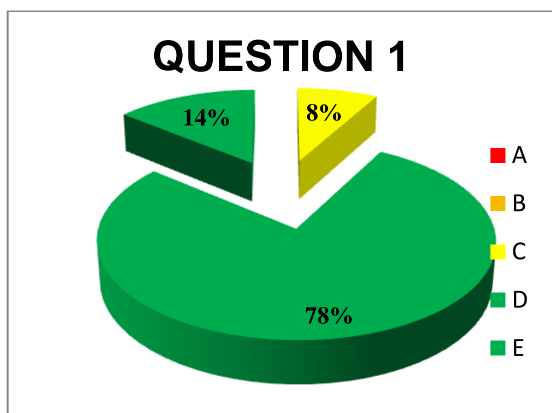
E 54% Green: The reporting of safety issues are second nature to staff who are confident in reporting & investigating processes. Robust risk management and learning systems are in place and best practice is recorded. Patients are able to report their safety concerns. An open policy exists in informing patients or carers about all types of incidents.

5.0 Responses about the safety culture of individual teams

There were again a wide spread of responses, whilst no one responded A to any of the descriptors there were more responses to B than for the organisational responses. Seven out of 8 answers were the majority rating D which continues the theme that teams are proactive thinking about safety issues that may occur in line with the organisational rating. Five of the dimensions had B responses however three of these were statistically insignificant. Again the majority of B responses were in Question 6 and Question 8.

5.1 Areas of strength in teams

An overwhelmingly high percentage of staff (78%) responded positively to question 1 – good practice and continuous improvement is high in individual teams, similarly priority given to safety scored high.



Q1 Good practice and continuous improvement

D 78% Green: Continuous improvement in patient safety is seen as the responsibility of staff, patients and the public and is actively encouraged thru the organisation. Staff are involved in the development of policies and procedures which form the basis of service improvement

6.0 Comparisons between organisational and team culture

6.1 Of note is the widest variation in 4 questions.

Question	Organisation	Team
Q2 Patient Safety	57%	87% ↑
Q5 Learning from incidents	82% ↑	75%
Q6 Communication about safety issues	79% ↑	62%
Q8 Team working	56% ↑	42%

The variation in responses suggest that teams view patient safety higher within their individual teams than it is viewed in the organisation as a whole. Communication about safety issues works well within the organisation but that this does not always translate through the individual teams.

7.0 Recommendations

Whilst it is encouraging to recognise that the safety culture of the organisation and individual teams rated as proactive in developing a safer culture, a number of recommendations can be drawn from the limited survey.

- The organisation scores well in reporting and evaluating why incidents have occurred however less so in wider learning shared across the organisation. This supports the move to have an organisational learning programme from incidents, near misses and never events looking to 'could this happen here'. This will form part of the work from CLIP and the use of 'Risky Business' newsletter. Divisional Medical Directors are discussing how to disseminate learning across their divisions and ensure medical staff are included.

- Teams don't all recognise how their team can be interdependent on other teams within the organisation. This is supported with higher responses in increasing pressure within 'my team', making difficult decisions becomes difficult, less support from others. This supports the move to include human factors training underpinning all clinical and non-clinical skills training as supported by the NHS England publication, Human Factors in Healthcare: A concordat from the National Quality Board Nov 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf The Trust has an emerging faculty for Clinical Human Factors Training as part of the education and training team with the

SIM ward as a central focus. It would be beneficial to the Trust to harness the learning and expertise developing within this group to support further skills based multi disciplinary learning and for the group to feed in to the governance of patient safety.

- The introduction of improvement methodologies to transformational practice changes identified through the Change Programme is now supported by designated project managers reporting to the head of performance
- Increased multi-disciplinary training together to understand the value of team working and improved communication through the use of human factors training
- Further deep dive into individual team safety culture as part of directorate working discussed locally through the divisional route.
- Safety culture review becomes part of an annual review of organisational culture across all non-clinical disciplines areas as part of an organisational ‘barometer’ review.