The Regulation and Quality Improvement Authority

Developing an Open, Just and Learning Culture in Health and Social Care in Northern Ireland

What Needs to Change to Make It Happen?

Summary of the RQIA Hosted Roundtable

Titanic Centre, Belfast

23 May 2024

1. Context

As part of its Duty to promote improvement in the quality of HSC services, RQIA hosted a Roundtable Event in the Titanic Centre, Belfast in May 2024, inviting senior leaders, clinicians, patients, family members, carers, policy makers, commissioners and others to discuss the issue of patient safety in the context of developing an open, just and learning culture across health and social care (HSC) in Northern Ireland. This event builds upon the previous RQIA "Speak Up" Roundtable in Malone House in November 2023 and the Workshop for senior leaders in the HSC with Dr Henrietta Hughes, the Patient Safety Commissioner for England, in May 2024.

The discussion was anchored through listening to those with lived experience, who powerfully described the impacts when people and organisations across HSC are not open, particularly when things go wrong. There were insights shared by those who have experience from the legal sector, and from the UK and Ireland regulation and ombudsman services. All recognised the challenges and are also trying to address this persistent issue, which is adversely affecting patient safety.

Public Inquiry after Inquiry demands culture change, for the sake of patient safety. The discussion was directed, through three facilitated Panel discussions, to discover what will it take to create and sustain the necessary fundamental change in culture?

This paper sets out the elements of what RQIA heard. The purpose of the Roundtable was to explore the issue collectively and to seek out a way forward collaboratively. The event enabled the Authority to consider how best to use its role to encourage and enable this essential work.

The reflections on what we heard are set out in this paper and provide an outline of a way forward.

2. Patient Safety Culture - Outline of a Way Forward

The Roundtable discussion centred on three aspects of patient safety: Being Open; Creating a Just Culture; and a Learning Culture. Each of the panel discussions anchored around lived experience and much of it reflected on what had happened; and the consequences of not having an open, just and learning culture. The experiences shared were powerful and painful. Taking what we heard across the panel discussions, and the comments and thoughts participants left in their reflections, RQIA identified common features of each of the three discussion panels, with delegates raising questions and comments, and have set out an outline of a proposed way forward taking this emerging consensus into account.

What needs to happen?

1 There is a need to put in place the policies and processes that enable openness from all who work in health and social care services in the region: and actively support openness to listening to and acting on what is heard from patients, families and staff. These are the policies and processes that will allow a just culture to function: examining problems, concerns and errors, in a swift, responsible and proportionate way. These must inform and support polices and processes for learning to be applied promptly and widely, so as to minimise the potential for recurrence.

We have called this the 'Architecture'

2 Individuals, and especially those working collectively in teams, services, directorates and corporate bodies must demonstrate the required approaches in their attitudes, use of language, and by practical and consistent actions that deliver openness, a just approach and a learning culture.

We have called this the 'Behaviours'

3 The Architecture and the Behaviours we heard about are important to creating an open, just and learning culture, but will they alone achieve it? How will we know? The Roundtable discussed how a culture focused on patient safety can be identified, and can it be measured? It was clear from the participants that the culture of an organisation is experienced and can be described by those who use its services; those who enter into its facilities; those who attempt to engage with it; those who work in it; and those who observe it- whether in its routine delivery of services, in its relationships and its response to challenges, or in the extremes. And changes in that culture can also be described.

We have called this 'Culture Change'

The following narrative (and summary infographic) describes some of the things we heard that should be part of these elements.

Health and Social Care Patient Safety Culture

What Needs to Happen to Change the Culture?
RQIA Hosted Event - Titanic Centre, May 2024

Architecture

1. Visible, accessible people, policies and processes.

2. Process must not be used to avoid openness.

3. Need consistency in policy and processes across HSC services.

4. Learning process must be prompt and actions applied widely and sustainably.

5. A legal framework in 'Duty of Candour' cannot be awaited – act now'.

6. Statutory Duty of Quality and HSC Quality Standards; Professional Codes and Regulation Framework already exist. Build on what we have.

Behaviour

1. There is protection in the truth - this forms the basis of a just culture - truth from the outset

2. "Walk the walk" of the behaviours required; and be clear, these are not personal style, they are required of all

3. All should be able to respectfully call out or challenge unacceptable behaviours; and Leaders and peers have moral obligation to do so

4. Build and support teams to work together, and people are not left to work in isolation

5. Openness must be embedded in all parts of the HSC, not exclusive to or confined to a particular policy, process, issue, or area.

Culture Change

1. Recognise, culture is embedded -and it is learned

2. Recognise culture can be described and evidenced

3. Recognise there are many types of culture: the focus here is on the culture that affects patient safety

4. Work together to develop a HSC Patient Safety Culture Assessment Framework

5. Use it systematically to reflect on issues we need to focus on and to chart and review progress.

Architecture - What we heard

1. People, policies and processes that promote speaking up, listening, and acting on what's heard, must be visible, easy to use and approach, and accessible. This can't be limited to posters and sentences in a letter or leaflet, but must be built into conversations as the norm.

2. People, policies and processes must not be used to avoid being open or avoid facts being revealed that need to be addressed for patient safety. This includes freedom of Information processes and misusing legal processes to avoid or delay investigating an issue or sharing the facts.

3. People, policies and process that enable speaking up, listening, and acting on what's heard, give a means to achieve improved patient safety. While a wide range of ways exist to do this, consistency across HSC organisations in Northern Ireland is important. Consistent policies and processes should be familiar to all staff across the region and to service users, families and others, regardless of the organisation or service, building confidence in the credibility and integrity of the collective HSC and those within it.

4. Implementation of policies and processes that focus on learning, whether personal, organisational, or systemic, must be prompt and visible. Actions must be timely and sustainable to minimise the potential for recurrence of error or accident.

5. Legislation aimed at ensuring openness and candour in HSC organisations and for professionals may not have the effect intended – some UK jurisdictions are re-examining their arrangements for 'Being Open' despite having a legal framework in place. A legal framework in 'Duty of Candour' should not be awaited to tackle this issue here. We must act now.

6. The statutory duty of quality already exists (2003 Order), the HSC Quality Standards already exist (2006) and set the requirements for an open, just and learning culture; a regulatory framework and HSC Quality Improvement Programme already exists (2019). There is potential to collaborate around what we already have, and to add to and refine what we have in place. The mechanisms are already available.

Behaviours - What we heard

1. There is protection in the truth: people who are open, honest, truthful and who are prepared to reflect and learn, should be treated fairly and justly. Failing to be open and honest will destroy any just culture for the people who work in health and social care; and denies patients, families and staff the opportunity to take positive steps about their own situation, in possession of the honest facts.

2. Be explicit about the behaviour expected of health and social care individuals and of corporate bodies acting as a whole. Individuals role modelling the behaviours that must be displayed by all individuals working in HSC is very positive act, but it is not sufficient to ensure it is recognised as an organisational requirement, rather than simply a personal style. Spell it out: these are the behaviours the organisation requires, and is committed to - it's not a style and it's not optional.

3. Unacceptable behaviour, whether in in terms of engaging with a colleague, a member of staff, a collective group, or responding to issues raised, internally or from patients and families, (in all verbal and written formats) must be respectfully called out by peers and senior colleagues. Otherwise that unacceptable behaviour will continue to be repeated and wrongly emulated by some, misinterpreting it as organisational policy, professional practice, or otherwise permissable – it's not, it's poor behaviour and not supportive of an open, just and learning culture.

4. Build and support teams to work together, and people are not left to work in isolation.

5. Openness transcends all levels of service activity. It is essential in the routine delivery of services and in the management and oversight of services, and when things go wrong. Openness must not be exclusive or confined to one function or policy or issue. It must be adopted as our standard practice.

Culture Change - What we heard

1. Culture is "How we do things around here (when no one is looking)". It's in the unwritten rules and policies; it's observed and experienced; it's learned as new people join the organisation. "This is how we do things here" explicitly or implicitly demonstrated, at first hand. This is how culture develops and persists, even when people change and structures change and new policies come into effect. It gets embedded.

2. In order to change it, we need to hold a mirror up to it, shine a light on it. It can be detected and evidenced.

3. There are many different cultures going on in an organisation, focused on different things. To change the culture relating to patient safety, we need to detect and evidence the culture that affects it. That's the culture around being open and honest, in all things and at all levels. It's about developing and maintaining skills. It's about creating a just approach; and actually looking to learn from mistakes, and accidents, and doing things that deliberately act to avoid repeating such mistakes, accidents, errors and harm.

4. We can, must and will develop a HSC Patient Safety Culture Assessment Framework. It must be developed collaboratively if it's to be an enabling initiative, a just and supportive one, not a threat or stick. The evidence that comes from the patient safety culture assessment will contribute to driving culture change; it will prise out the issues that need attention and empower individuals and organisations to address them.

3. Summary

The Roundtable event at the Titanic Centre (May 2024) has enabled the setting out of an outline of what needs to be done to change the patient safety culture in HSC in Northern Ireland. To develop an open, just and learning culture:

There needs to be **'Architecture'** in the form of people, policy and processes to enable openness, a just approach and prompt applied learning; focussed on a culture of patient safety, consistently across the region

There needs to be consistency in **'Behaviours'** of individuals, teams and corporate bodies that display openness at all levels, in the routine and in the extreme

There needs to be a means to measure and evidence **'Culture Change',** that shines a light on the persistent issues that erode patient safety, and promote those actions and attitudes that improve patient safety. This will direct efforts to the issues that are inhibiting positive change and help chart progress

Action

RQIA will lead the development of a HSC Patient Safety Culture Assessment Framework.

- **It will be developed collaboratively, with HSC Trusts and other HSC bodies, Trade Unions and professional bodies, patients, families, carers and victims**
- **It will seek out the indicators, evidence and measures, that are essential to positive patient safety culture change and use the Framework to report findings**
- **This will help focus on the key issues that need attention**
- **By reporting it will help openly chart our collective progress**

This work will start now.

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