



Mersey Care
NHS Foundation Trust

Community and Mental Health Services

A photograph showing a woman from the side, her hand resting on the shoulder of a man whose back is to the camera. They are in a brightly lit room with large windows in the background. The woman is wearing a dark top with a patterned collar, and the man is wearing a plaid shirt.

Supporting Just and Learning Culture

A four step process for managing our
people processes in a supportive way

Supporting Just and Learning Culture

A four step process for support and managing people practices in a supportive way...

The aim of our Just and Learning approach at Mersey Care is to improve the safety of all our people. We recognise in every human system mistakes will happen. In Mersey Care, we know we operate in one of the most complex environments and how we respond to those mistakes is critical to our aspiration to deliver perfect care in a just culture.

Creating a Just and Learning Culture is a commitment to our workforce and to our patients that our organisation will take every opportunity to learn and improve. Our aim is to create a compelling place to work, where we attract, retain and develop people to be the best they can be and deliver the best care.

Our next phase of work focuses on how we truly facilitate a restorative approach when things don't go as expected. We are using a **Restorative Just Culture** theory and our own experiences of application, to inform how we learn from incidents/events in a truly supportive and compassionate way.

Focussing on why it happened, we can then understand and make sense within the context and environment in which it occurred. In a Just and Learning Culture it is only appropriate that we take preventative action to identify processes that exacerbate the potential for error, and most importantly, celebrate the abundance of strengths and successes that occur throughout our working day.

We recognise for some our practices and approaches may have caused hurt. Some of our hurt was documented in a powerful film which was released in April 2018 which documented our journey to this point. The film came from the academic and restorative justice expert Professor Sidney Dekker of Griffith University and can be seen here: bit.ly/JustCultureTheMovie.

As Director of Workforce I know we have some way to go but we are continually striving to learn and improve our people practices. We recognise that the old ways of identifying the causes of harm in patient care was often inhibited by a fear of being

blamed by the very procedures in place to protect people. This does not detract from one of the Trust's core values of accountability. As health care colleagues we all have accountabilities to improve patient care and experience but we also have the same accountabilities to each other. I hope that through this four step process, we enable more of our people practices to reflect respect and civility every time, every contact.

Accountability

Mersey Care staff are responsible and accountable for performing their duties, behaving in accordance with our staff charter and all our values. An account is something we give or expect those involved to give. So to enable organisational learning by increasing our understanding of the impact of the incident and how to put things right.

A Restorative Just Culture approach will help guide the organisational response in the aftermath of an incident or event. This approach really brings our organisational values and the Trust's work on civility and respect to life.

Just and Learning Culture

Our view is that for the vast majority of incidents, the formal investigation route is neither appropriate nor helpful to reduce the probability of future incidents and it also places a considerable strain on our people and can lead to creating more victims and hurt. Instead, we prefer to view incidents and events that didn't go as expected as learning opportunities to help us grow and improve as an organisation.

Through the application of restorative Just Culture techniques, we recognise that saying a formal investigation, suspension or exclusion is 'non-prejudicial action' does not feel like that to the member of staff concerned. HR work tirelessly with operational managers and unions to keep investigations and suspensions to an absolute minimum.

This is really important for their psychological wellbeing and safety. Alongside this we have developed improved access to occupational health, staff support services and resilience programmes. There are other initiatives including our Supporting Colleagues Policy, Just and Learning ambassadors

and specific training for managers. Where we have found that policies and processes are not conducive to our Just and Learning and restorative approaches, we aim to change them. In any large, complex organisation this will be the tip of the iceberg and we'll continue to look at this to make sure our structures, policies and processes support, not hinder our ability to do our best work.

Through the application of Restorative Just Culture techniques, organisational learning may be identified and will focus on distinguishing between causality v contributory factors. On occasions individual needs may also need to be identified, ranging from reflective practices, supervision, training or performance / behavioural needs. Indeed, a Just and Learning culture should embody both fairness and accountability, so formal action may still be required in exceptional cases but this is never our preferred choice.

What's next?

We have come a long way as a Trust but there remains more we can do. That said, I am very proud of the progress we have made and continue to make together. The demand for us to share has led to the development of a four day Restorative Just Culture programme. We've done this in collaboration with Professor Dekker and partners of Northumbria University.

The pilot for the programme was delivered internally and has led to further learning and development needs. A number of actions taken away included the development of this four step approach and a one day programme to support our managers and staff to have restorative conversations and navigate historical barriers to doing so. These will help to cascade the techniques around restorative just and learning conversations with colleagues. We have also developed a short e-learning tool, to support colleagues in our own organisation and across the NHS –

https://www.mersecare.nhs.uk/justandlearning/story_html5.html?lms=1

Amanda Oates

Executive Director of Workforce

Introduction

Please remember, there can be multiple victims affected as a result of an adverse event, simply speaking they can be:

1. **First victim** – are generally the patients, service users and their families who are involved in an incident which causes them harm or injury.
2. **Second victim** – are generally practitioners who are involved in an incident that causes harm or injures someone else and for which they feel personally responsible.
3. **We also need to remember** other victims can extend to the wider team, patients, (the community), the organisation as well as practitioners families.

"All Boards need to ask themselves – how do they know staff in their care don't feel hurt by the very policies and processes meant to protect them and to deliver the best possible patient care? My Board has asked this very question, and whilst we can demonstrate significant improvements, we know that we have more to do."

Just and Learning Culture has been led from the Board but we are all guardians of it. I want to take this opportunity to remind you of our commitment to creating that culture and enabling our staff to deliver it."

Beatrice Fraenkel

Chairman

"At Mersey Care, we have spent the past few years refining our approach to a Just and Learning Culture so that we can encourage colleagues across the trust to feel supported in learning from best practice at every turn and in also speaking out and extracting learning when things don't go to plan. This is important if we are to continually improve patient safety and behave openly and transparently with the public."

This approach has also surfaced stories of where Mersey Care as an employer didn't get it right for our colleagues across the trust. This has generated some powerful and often humbling learning for leaders to hear and has strengthened our commitment to ensuring that we continually demonstrate compassionate support for all of our people, all of the time."

I would therefore like every person in the trust with line management responsibilities to ask yourself whether you are doing enough to support your colleagues and what more you could do to make working here at Mersey Care better for everyone."

Joe Rafferty

Chief Executive

Restorative Just Culture Guidance

* A TOOL THAT ALLOWS YOU TO UNDERSTAND THE EVENT *This needs to be explained to the colleague By the manager

STEP 1 – TRIGGER POINT

.....**The event – could be something that has not gone as planned**
 An event that could have caused or did result in harm to people or groups of people. This can include psychological harm and feelings of hurt, or physical harm even or damage to property.

STEP 2 – ALWAYS REMEMBER – this should be led by a individual manager- there should only be 2 managers if one manager asked for support for their own development needs – If you do not progress into step 3, you must always undertake step 4

Always remember <i>(these are your prompts when reviewing)</i>	Comments
Stabilise the situation This does not include removing anyone from work, their workstation or restricting duties unless the safety of patients and staff require it	Do you need to move the colleague as an interim measure to support? Is there potential for service user harm by not moving? Provide reassurance no decisions will be made until explored further / all the facts are gathered. Stabilising the situation involves potentially many other actions, such as first aid, (formal) reporting, inform patients, prevent same event happening again etc. Also: manage 'wrong' responses to event.
Ask, who is hurt? This can include service users, service providers, other staff and/or people external to our organization (could be physical, financial, psychological, social)	In answering this you need to understand the hurt and how it has impacted but you need to ask them the question, not assume you know Colleagues may feel stressed, failed by the Trust, witnesses feeling awkward and/or uncomfortable. Hurt is not only about feelings, can also be damage / missed treatment etc.
What is their need? Support, include clear communication plan, regular and timely. Consider staff support policy, interventions, etc.	Always ask what they need as it may not be obvious. Do they need staff side? Can include Resolution/ closure, support, a link person, effective communication, however it is necessary to be clear that this can be wider than HR matters- this is to prevent it happening again
Whose obligation is it to meet that need? Someone especially assigned to ensure the restorative process is properly applied.	Eg: often the organization (represented by roles/staff members), management, staff side, HR, support resources available. Everyone needs to be clear on what their responsibilities and expectations are- need to be clear on who is best placed to decide this
What is the understanding of what happened? Did it make sense? (consider why it made sense to the individual)- ask for a written account regarding the event to gain a full understanding.	This is the key question as the only way we can understand this is if the individuals can give their accounts and be listened to. Consider historical practice, custom and practice, cultural sensitivities? Do not consider the norm as this is only relevant for step 3
Are the resources available and appropriate?	Consider staffing levels / numbers, observations, resilience, resources required to manage the 4 step

*** some steps may overlap as you don't have linear conversations ***

STEP 3 – MERSEY CARE GATEWAY- if satisfied at step 2, do not need to move to step 3, but should always consider the personal and organizational learning at step 4 and refer back to step 2 as required. If colleague is a member of a union, should disclose documentation if requested

An investigation into anyone's individual actions is only warranted if all of the below that are applicable are true: (are all the answers to applicable questions yes – if so it reinforces that we have handled in the correct way, normal processes and appeals will then apply	Comments
Are rules available? Accepted, practiced and in place? E.g. patient confidentiality	E.g.: SOP's, policies, professional code of conduct, unwritten rules/standards/accepted practice
Are the rules workable? Do they make sense in the context, environment, in the routine, consider work as done versus work imagined?	Recognising if they are workable in the timescales given. Have they chosen not to work within the guidelines? Have they chosen... is under 'were departed from'
Were the rules knowingly departed from? Is there awareness that people's actions were diverging from what is described? Rules that made sense to you at that time, values	Unconscious human error is no reason to invoke a formal process, this is not only about unconscious human error, also other unconscious deviations from rules- this should link back to the understanding of the circumstances of the event- why did it make sense?
Exception to peers? Is the behaviour very different to what colleagues/peers with comparable experience and skills would do in similar circumstances? If the answer is yes, then it is in exception to peers.	Are others in the same circumstances knowingly breaking the same rules, why only knowingly? 'would others have responded similarly...?'
Was training available? Consider the availability, quality and regularity of the training, and whether that was appropriate for our people and the situation. (if applicable)	E.G induction, mandatory training Is this appropriate to the alleged situation? Was the training appropriate for the event, if not, the answer may be no
Sufficient supervision – Was it provided? Take into consideration: a. Does the supervisor or manager know the work as done? b. Does the supervisor or manager know the work as done, but didn't realise it was a departure from the rules? c. Does the supervisor or manager know the work as done but doesn't act? (Does the manager understand the job / process of a task / duty etc?) Further action is only warranted if all of the above that are applicable have been answered by yes. If this is not the case, Mersey Care will not investigate any individual nor pursue disciplinary actions.	Important organizational learning – may include coaching, supervision, training, systems / processes. This could even be an alert on a system that provides a prompt / reminder e.g. when accessing patient records an alert will flag asking if you are authorised to view the records . Was the supervision applicable for the event, if not the answer may be no

STEP 4 – CONFIRM THAT THE RESTORATIVE JUST CULTURE GOALS HAVE BEEN ACHIEVED

have we been successful in applying Restorative Just Culture?	Comments
Moral Engagement Were we able to engage all parties mentioned under Step 2 in considering the right thing to do?	Has there been an apology and done correctly (see guidance) ? Have all colleagues had the opportunity to reflect and re-
Emotional Healing Were we able to help cope with guilt and humiliation; did we offer empathy?	Consider sign posting, what is the need, don't assume refer back to step 2, this may be an on-going process, check ins
Reintegrating Practitioner Were we able to do what was needed to get staff members back in their job?	Ask what they need, don't assume, refer back to step 2, how can this be accommodated and by whom and in what timescale- may be on-going process, check ins
Organisational Learning Explored and addressed systemic causes of harm (this is best enabled through a learning review process. It is an important step for every organisation to be able to identify systemic	Important for the recovery process- can be thematic or individual- need to evidence. What have we

Note:
Restorative Just Cultures aims to repair the trust and relationships damaged after an incident.

It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.

Restorative Just Culture Checklist – Professor Sidney Dekker, Griffith University

Respect and civility
EVERY time, EVERY
contact

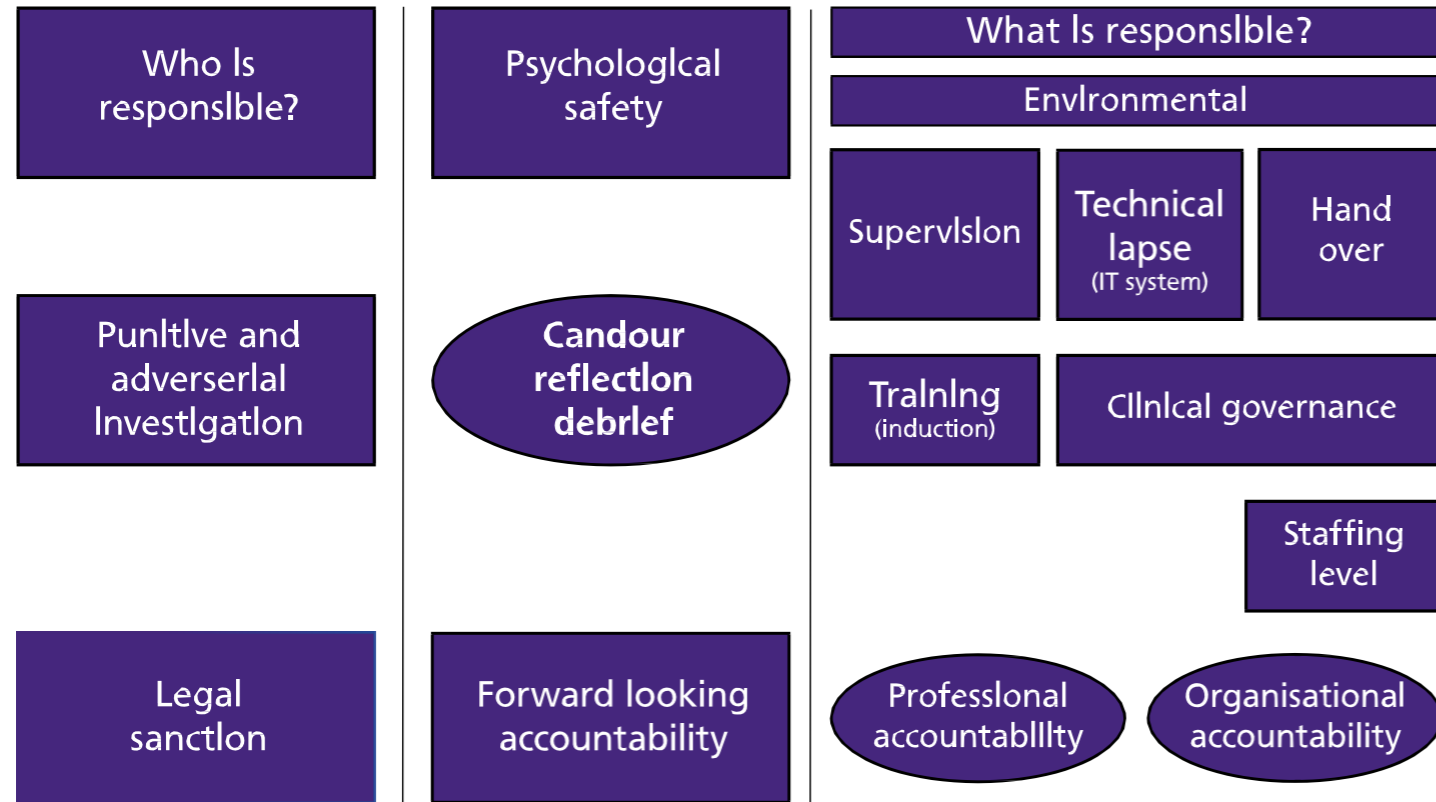
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Just and Learning Culture

Distinguishing causality vs contribution



The journey to a Just and Learning Culture

Our people and/or teams operate in a healthcare system which is inherently risky though more often than not, we achieve better outcomes for patients.

Learning and change in practice is better achieved by studying the system and context in which incidents occur rather than analysing individual practice.

Rather than trying to identify a single root cause, attempts to understand the contributory factors promotes psychological safety and also facilitates deeper learning and adoption of better



On occasion, forgiveness for the hurt caused may not be realised for a very long time or it may never be. This will be difficult, but ~~the process of forgiveness is about addressing the needs of the~~ person hurt and learning and figuring out how to be better in the future.



The Four Step Process

The Four Step Process has been prepared by and is the intellectual property of Mersey Care NHS Foundation Trust (the “**Creator**”). The Four Step Process was developed using NHS Improvement’s Just Culture Guide (see <https://improvement.nhs.uk/resources/just-culture-guide>) and Professor Sidney Decker’s Restorative Just Culture Checklist (see <http://sidneydekker.com/wp-content/uploads/2018/12/RestorativeJustCultureChecklist.pdf>) with input from University of Northumbria at Newcastle (“**Northumbria**”).

The Four Step Process is provided free of charge by the Creator and/or Northumbria to healthcare professionals only and solely for general information purposes. The Four Step Process should only be used by people who have been trained internally on the four day Restorative Just Culture programme delivered by the Creator and/or Northumbria in collaboration with Professor Sidney Dekker and partners of Northumbria.

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**Mersey Care NHS
Foundation Trust**
V7 Building
Kings Business Park
Prescot
L34 1PJ

Tel: 0151 473 0303