

Creating the conditions to develop and nurture a culture of safety

Creating a culture of safety is an essential foundation to delivering safe and reliable care and ensuring that patient safety is at the heart of all care delivered. When things go wrong they can often be tracked back to problems inherent in the system, human relationships or behaviours and attitudes to safety.



Leaders have a duty to ensure the safety of both patients and staff and must foster a climate that avoids harm, promotes learning from error and excellence and enables staff to drive continuous improvement in the areas they work.

The culture workstream supports teams in NHS organisations to develop and nurture a culture of safety and the ambition to:

- raise awareness of the relevance, and impact of team culture on safety
- build capability for changing culture at different levels
- Influence and create the key conditions to allow safety to flourish

The programme engages leaders and teams to work on initiatives and interventions to develop a culture

of safety. Team culture shapes values, behaviour and relationships, which in turn affects both the way care is provided and the experience and outcomes for patients. By focussing on activities that address the components of culture and learning such as communication, teamwork, leadership and psychological safety teams can start to address the clinical and operational factors that are critical for achieving safe high quality care.

These interventions include:

- culture survey and debrief
- leadership development for safety
- positive reporting and learning from excellence
- safety huddles
- enhanced team working
- structured communication.

Learning from Excellence – how positive feedback is changing culture



West Midlands PSC developed and supported Learning from Excellence (LfE) to improve quality and safety of care through recognition and learning from what is working well and improving morale of staff through positive feedback. They are linked in a virtuous cycle and sit alongside incident reporting and other quality improvement methods.

LfE is currently being used in 100 centres across 5 counties with a growing community of practice in the West Midlands.

The PRAISe (Positive Reporting and Appreciative Inquiry in Sepsis) study in Birmingham Children's Hospital showed measurable increase in positive behaviours after using the LfE approach.

"It's really important that staff are given positive feedback that they deserve. We've seen a change in our unit since we've started using LfE. We've seen change in practices, staff have been a lot more positive."

Lauren Dowd

Clinical Research Nurse at Birmingham Children's Hospital

Safer Culture, Better Care – the 'SCORE' survey

South West PSC has used a validated assessment tool for safety culture, using a survey called SCORE (safety, communication, operational risk, resilience and reliability, and engagement).

The survey is an internationally recognised way of measuring and understanding the culture of teams. It provides detailed feedback in communication, staff burnout, resilience, leadership and teamwork and a framework to help address team culture and facilitate change.

Using safety culture survey can have an impact. An emergency department in Plymouth used the survey with its 250 staff, across all roles. During debriefing themes emerged about

burnout and the causes of burnout and unhappiness. As a result, the department has tackled staffing issues, overcrowding and lack of space, taking evidence from their safety culture survey to the board.

The South West was the first region in the UK to use this type of survey, and has since supported PSC colleagues and the national Maternal and Neonatal Health Safety Collaborative by providing training in the use of SCORE and effective debriefing. The PSC workstream is focused on the outcomes of safety culture surveys and has developed a toolkit to support teams in using safety culture surveys as an intervention for improving safety culture.

Over
9,000
staff surveyed
in **96** healthcare
settings in the
South West



Patient Safety Collaborative