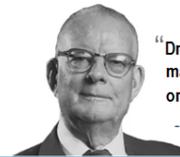


Improving the NHS Safety Culture

Improvement
Academy

We need a 'No fear' culture—Deming

W. Edwards Deming, statistician, engineer and guru of the Quality Improvement movement who transformed the quality of Japanese manufacturing in the 1950's, had "no-fear culture" as one of his fundamental principles of quality improvement. This bulletin concentrates on what we have been learning about improving culture across Yorkshire and Humber.



"Drive out fear, so that everyone may work effectively for the organisation."

- W. Edwards Deming

Teamwork and Safety Climate Surveys



Whenever the Improvement Academy is involved in supporting teams to improve quality and safety we encourage that team to start with a **team culture survey**. The 28 question validated questionnaire, developed by the University of Texas, is both a diagnostic and an intervention to improve culture. This has now been adapted for use in many different healthcare settings. Since 2013, we have worked with over **400 teams**, analysing over **10,000 individual surveys** across over **30 organisations**.

Why is it important to measure team work and safety culture?

- ◆ Disharmony within any team is a distraction and means that the team won't be in an optimal position.
- ◆ A highly dysfunctional culture where there are disparate scores amongst team groups - whilst rare - is a strong indicator of clinical risk.
- ◆ When there are very different perceptions and individuals are not happy there is always a 'price to be paid' in terms of safety.

What does a sound safety culture look and feel like?

- ◆ Every member of the team, regardless of their role and professional group, feels valued.
- ◆ Everybody also feels like they can speak up if they feel worried about a patient (Psychological Safety).

What does the research tell us?

- ◆ Safety Culture "lives" at team level and therefore has to be measured there.
- ◆ A team that works together well is a safe team.
- ◆ The degree to which nursing input is positively received, particularly by doctors, correlates with patient outcomes.
- ◆ Commonly, doctors will believe that the team works really well together but other team members often don't agree.

What's the Improvement Academy's observation and theory?

- ◆ We've surveyed hundreds of teams over many years and, without exception, teams tell us they find the survey helpful.
- ◆ When teams are equipped with insight into how they work as a team and how safe they perceive their care to be, they feel empowered to take action where necessary.
- ◆ The process of measuring, analysing and giving the team their results is an intervention in itself.
- ◆ The majority of the elements of the survey are within the gift of the team to improve.

"In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime." Don Berwick, 2013

For more information about use of culture surveys in your organisation please contact **Vicky Padgett**.



Supportive culture for staff experiencing distress following a patient safety incident



Our new **Second Victim Support website** is helping organisations to provide a supportive culture for staff who have been affected by patient safety incidents.

We are offering a workshop for organisations that are interested in learning and sharing work across organisations. This is taking place in Leeds on 4th April 2019. To find out more contact **Iona Elborough-Whitehouse**.

STOP PRESS: Adam Kay speaking at our Improving Patient Safety Conference 15-16 October 2019

We are very excited to announce that **Adam Kay** and **Mary Dixon-Woods** will be among the speakers at our '**Improving Patient Safety: new horizons, new perspectives**' two-day national conference in the Autumn. The **call for Abstracts** is now open—closing date Friday 31st May 2019. **Early Bird rates** are available until 31st July 2019. For further details and registration check the **conference website** or our Twitter page **@IMPSAF2019**.

Improving
Patient Safety

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