Tackling the blame culture? NHS Staff Survey Results 2020

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Summary

Patient Safety Learning reflects on the results of the NHS Staff Survey 2020, in relation to its 'Safety Culture' theme. The survey indicates that a significant number of staff continue have concerns about whether their organisation takes action to address patient safety issues, and that nearly a third of respondents said that they do not feel they would be treated fairly when raising a concern. This blog considers the patient safety implications of the persistence of blame culture in the NHS and considers the action that can be taken to address this.

Content

On the 11 March 2021 the NHS published the results of its annual staff survey for 2020.[1] This is one of the largest workforce surveys in the world, with 595,000 staff responding from 280 NHS organisations who were asked to take part.[2] The survey focused its questions on the impact of the Covid-19 pandemic and ten core themes used in previous surveys.

In this blog we will look at the responses that relate to the 'Safety Culture' theme, considering results around reporting and acting on patient safety concerns and how safe staff feel to speak up about patient safety issues. We will then consider what more can be done to create a safer culture in the NHS.

Reporting and acting on patient safety concerns

The survey asked several questions regarding the action taken on reported errors, patient safety incidents and near misses:

- 73.4% of staff said that their organisation takes action to ensure that reported errors, near misses or incidents do not happen again.
- 74.8% of staff said that their organisation acts on concerns raised by patients/service users.
- 60.4% of staff were confident that their organisation would address their concern.

The answers to the questions above reflect small percentage increases on responses in the previous year's survey. There remains however an alarmingly high number of staff, more than 150,000, who

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felt they could not respond with confidence that their organisation takes action to ensure reported errors or incidents do not happen again. As we noted in our reflections on the 2019 staff survey results, we believe that this is unacceptably high.[3] This degree of uncertainty about whether safety issues will be acted on would simply not be tolerated in other safety critical industries.

Likewise, the figure relating to acting on concerns raised by patients is troubling. At Patient Safety Learning we recognise the importance of engaging with patients to improve patient safety, with this forming one of the six foundations of safe care in our report *A Blueprint for Action*. The response to this question from staff in the NHS supports the notion that still too often patient safety concerns raised by patients and family members are not being acted on.[4]

Feeling safe to speak up

The survey also asks several questions regarding how safe staff feel about speaking up about errors, patient safety incidents and near misses:

- 60.9% of staff said that their organisation treats staff who are involved in an error, near miss or incident fairly.
- 62.7% of staff said that their organisation gives them feedback about changes made in response to reported errors, near misses and incidents.
- 72.5% of staff said they would feel secure raising concerns about unsafe clinical practice.

Commenting on the survey results, Dr Henrietta Hughes, National Guardian for the NHS, said:

"The fact that nearly a third of those who responded do not feel safe to speak up shows that there needs to be a more consistent approach from senior leadership throughout the health system to ensure that all workers are thanked, supported and listened to whenever they speak up."[5]

On the question of whether your organisation would treat staff involved in a patient safety incident fairly, approximately 230,000 respondents felt they could not say that this was the case. This provides evidence of the continuing influence of blame culture in parts of the NHS.

This is also supported by the results of the recent Freedom to Speak Up Guardian Survey, in which 33% of respondents could not say that their organisation had a positive culture of speaking up.[6][1] How this manifests itself throughout the NHS would appear to be inconsistent, varying across different healthcare providers. The survey of Freedom to Speak Up Guardians noted on the question about whether an organisation had a positive culture of speaking up that there was strong correlation with Care Quality Commission ratings, noting:

"In 'requires improvement' rated organisations, 43 per cent of respondents said their organisation had a positive speaking up culture, compared to 91 per cent from respondents in 'outstanding' organisations".[6]

Moving towards a Just Culture

It is widely acknowledged that to ensure patient safety incidents are consistently reported and acted on, staff need to feel safe to do so. This requires an organisational culture that supports and promotes this. At Patient Safety Learning we recognise the crucial role culture plays in patient safety, identifying this as one of our six foundations of safe care in our report *A Blueprint for Action*. To improve patient safety, it is important to move towards a Just Culture; a culture less focused on blame and which "considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution".[7] This has a positive impact on patient safety, creating an environment where individuals are supported in raising and resolving concerns, addressing incidents of unsafe care with empathy, respect, and rigour.[8]

This is identified as a key element of the World Health Organization's *Global Patient Safety Action Plan 2021-2030,* as part of its objective to build high-reliability health systems and health organisations that protect patients from harm.[9] It sets out a number of actions for governments and healthcare providers aimed to:

"Develop and sustain a culture of openness and transparency that promotes learning, not blame and retribution, within each organization providing patient care."[9]

Improving safety culture in the NHS

The need to move towards a Just Culture is recognised by the NHS, identified as one of the two foundations underlying its Patient Safety Strategy.[10] However, as the Staff Survey results indicate, there is still a significant persistence of blame culture within the NHS. We also see evidence of this through our work and conversations with staff through our patient safety platform, *the hub*. We often see a reluctance to share examples of good practice, as well as unsafe care, with staff expressing their fear that they will be 'found out' and do not have permission to share good practice. Not sharing good practice is a huge barrier to learning and improvement.

Last year an anonymous healthcare professional shared a blog with us on *the hub* expressing their frustration about this, saying that while:

"Describing the ideal safety culture is easy, we are told to adopt a 'just culture', however fostering a culture of safety is not that simple, following a guide doesn't work."[11]

In its Patient Safety Strategy, the NHS sets out actions on patient safety culture around using the staff survey to understand perceptions of this and assessing whether organisations adopting and developing Just Culture guidance, embedding this through their work.

At Patient Safety Learning we believe that more robust and specific commitments are needed to drive forward the work of improving the safety culture in the NHS, working with the National Guardian and Care Quality Commission, as we highlighted when commenting on the NHS People Plan last year.[12] We believe that the NHS should take the following actions as a matter of urgent priority:

1. Just Culture
    - Ask organisations to develop and publish goals to create and sustain a Just Culture.
    - Ensure organisations measure and report on their progress in

an open and transparent way.
- Enable organisations to share good practice for wide dissemination and implementation.

2. Speaking Up

- Provide resources, guidance, support, and direction for organisations wanting to encourage staff speaking up.
- Proactively share examples where improvements have been made to speaking up cultures so lessons learnt can be shared widely and best practice implemented.
- Identify poorly performing organisations and intervene to make improvements.
- Report publicly on the progress and the impact that speaking up has had on patient safety and staff safety.

We believe that the implementation of the above actions would reassert the NHS's commitment to improving the safety culture across healthcare. As Sir Robert Francis QC said in his *Freedom to Speak Up* report in 2015:

"We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement. That is the way to ensure that staff can make the valuable contribution they want to offer towards protecting patients and the integrity of the NHS. Most importantly the risks to patients' lives and well-being will be reduced, and confidence in the NHS protected."[13]

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