Transcript: Transforming organisational culture principles and practice of restorative just culture - our journey

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[Joe]: Hello, everyone. It's a pleasure to talk about Mersey Care's journey, focussed on our use of the principles and practices of restorative just culture as a sort of mechanism, really, to begin transforming our overall organisational culture.

We started this work well over six years ago at this stage, and it was stimulated, really, by the sort of couple of years of work we carried out in the organisation ahead of that.

When we talked about establishing for the organisation a set of BHAGs, big, hairy, audacious, goals. Those of you familiar with the work of Jim Collins and Good to Great and so on will have heard that reference before.

But really, we had used the big, hairy, audacious goal idea to begin to develop the idea of zero acceptance of errors or mistakes in health care.

So we talked about zero suicide in our care, zero medication errors, zero restrictive practises and so on. And actually we hadn't set these as targets for the organisation, but instead talked about them as ambitions, so that really, we could use them as devices to free our staff’s thinking, to free up their ingenuity and imagination and so on, to look for different approaches to what are really some, you know, very, very complicated issues in health care.

And while this proved really, really popular with our staff, it gave us a very unexpected result. And that was at one stage our staff said, well, it's very interesting to talk about zero approaches in the organisation, but how about BHAG then for blame? How about a big, hairy, audacious goal that manages this whole phenomenon of blame in the organisation?

That was a pretty sort of arresting moment for myself and Amanda and the rest of the board and the organisation, because I guess at that point we would have said, well actually, you know, I'm not aware that we have a sort of predominant blame culture in the organisation.

You know, we were really focussed on our sort of positive sense of improvement and so on. And I guess at that point we sort of had that really critical issue that leadership has to deal with when you sort of had the moment of realising that there's a perception of what happens in the organisation at the leadership level that is different to what's happening on the frontline.

I mean we've since christened that the difference between work as imagined versus work as how it actually gets done. And on the next slide, I show why this was such a profound moment for the organisation.

We had about 400 senior leaders in the organisation where we did some close group work with them. And if I could have the next slide, I’ll be able to show you the result of that work, which we entitled Barriers to Transparency.

There was no question staff were enthusiastic about engaging in different ways of working. But the biggest barrier to them really being able to get on with this is demonstrated here on this donut slide where you see that 50% of our senior clinicians basically referenced fear, blame, shame, consequences, dismissal as a result of how they felt in the organisation when something turned out as they didn't expected it to.

And you can see on the other side of the donut really in effect it's a version of the same thing. We spend a lot of time doing incident investigations, took a lot of people's time and never fed back to them. And really in a sense, people felt that the organisation itself became adversarial to them in the event of a serious incident in the organisation.

So as a result of that, and at about the same time, Amanda Oates, who will come on the presentation next, had picked up the work of Sidney Dekker, started to talk about restorative justice culture. And it was at that time we thought, well, okay, we can't avoid this as a perception thing, so as a board we took it very seriously.

We understood that we had to do something that was really going to break open this issue about barriers to transparency and give us a set of tools that would move us forward from this position.

So at this point, Amanda will now introduce what we mean by just culture and talk a bit about its practices.

[Amanda] Thanks, Joe. So I think the really most important thing to understand is when you start on a journey, and particularly if you're using the terminology just culture, is what you actually mean by just culture, you personally and also your organisation which you're leading.

You may be aspiring to achieve something. Certainly in my experience — and Joe and I talk at these events extensively now — a lot of people talk about just culture, but when you actually say to them, “What does it mean to you? How would you define it in your organisation? What literature you're basing your assumptions on?” they don't know.

So it's just become like a new buzzword without people really understanding the connotations or the meaning or indeed the evidence base. So that's one thing I would certainly ask you to look at.

When I was exploring just cultures, I came across a number of academics, but two mainly. But the one that connected to me and the one that I found most beneficial was the work of Professor Sidney Dekker. And how he defines just culture is, nobody's account being right or wrong and really taking a step back, looking at an incident or event and then valuing the multiple perspectives, and from that, that encourages both accountability and learning.

And for us at Mersey Care, that's the definition that we've really held true to. So when people say to us, “What do you mean by just culture?” we say it's fair, because that's what just means. It's a fair culture. It's a culture that supports accountability, and we'll talk about that a little bit more in a moment, and also enables learning.

And that's really what you want within your organisation, everything you do and everything you go about. So if we look at the difference, because you can have retributional just cultures, and some people have instant decision trees or algorithms that say to you, you put somebody through the sausage machine and it comes out and tells you what to do with that individual or that incident, and that's not something that we really endorse within the organisation, although I will share with you what we've done around a framework later on.

So you know, the approach to just culture can be retributional. You could just fire somebody. That's not that just culture we mean. Or you could look at a restorative approach which looks at what you were trying to achieve in the long game. So if you think about it, if you look at your policies you processes in the organisation, and if you look to the retributional, if they say to you or ask you what rule was broken, who did it, how bad was the breach, and what should the consequences be, I would imagine you're following a retributional culture.

And that is absolutely counterproductive to, I think, the goals of most organisations, the goals of being able to learn, to prevent future instances reoccurring, being able to understand, really understand and sense make from the eyes of the practitioner or the staff member, review instances holistically, not through one silo lens, and actually use quite — terms like being able to forgive, being able to move on, and actually use the term that we've started to do a lot in our organisation.

When there's an incident that occurs, there tends to be a lot of hurt, and that's the staff member, the service user, the loved ones, the families and even the staff members' families. The impact that you have to have has to help heal those relationships and and re-examine and build trust once again.

Of course, we want to treat that hurt with healing, not hurt with more hurt. And that's the danger in these things, that you can actually treat hurt with more hurt.

Of course, if something isn't broken, you don't need to restore it, so always the advice is try and deal with something when it's downstream, not trying to restore it when it's upstream. So obviously investing in those relationships at the beginning are critical.

If you look at the restorative language, that actually asks who is hurt. And rather than jumping in to what are we going to do about that, we start understanding it from a different perspective.

What are those needs that that individual or group of individuals have, and whose obligation is it to meet those needs. And thinking about that, not just between one or two individuals, but the wider community. And that could be that individual's loved ones, families, from both a patient perspective or indeed from a staff's perspective.

And then if you have to restore something, that's the word that you have to consider right at the beginning, so thinking about that moral engagement, how we help somebody to heal. How do you integrate a practitioner back into the workplace if they've potentially been suspended? There's all this gossip and rumour of, oh, look what happened to Amanda. Amanda did this. How do you reintegrate a practitioner and expect them to come back to work and feel safe in the environment when that environment might have hurt them deeply or damaged relationships across the organisation?

And that's particularly profound if you ask the question at learning, and I think Joe and I would both reflect when we looked at the cases from many years ago, at best we got individual learning.

Now what we're trying to do is get that organisational learning. So it's cutting across the organisation, so the same things aren't reoccurring, and when we talk about prevention. So if done right, it can actually build to prevent similar clinical instances reoccurring time and time again.

So as Joe alluded to, staff wanted a BHAG. They wanted, very simply, to feel that they could work in a safe environment. Some of our staff deal with some of the most challenging and vulnerable people in our society. But we've got to recognise in treating vulnerable people, our staff can feel vulnerable too, and are indeed vulnerable.

So how can they come in to work and feel safe and feel treated fairly and compassionately? And that was their ask really. And really from that time on, and a lot of engagement with staff, a just and learning culture was born.

And I think what we wanted to recognise, you know, there’s that age old saying, isn't it, you know, culture eats strategy for breakfast. So you've got, you know, your tip of the iceberg is what you see, you feel and you touch, but there’s so many things going on underneath an organisation. And indeed us as individuals, we're very complex beings.

So if you think about what we wanted to achieve within our organisation is, how do you balance that between being a just and fair culture to developing a culture that doesn't feel that it's punitive. And that we foster learning, but we recognise that could only happen if we responded to our incidents or events within the workplace in a compassionate way.

It doesn't ignore responsibility or professional accountability, restorative just cultures, and that was often the fear when we first started. You know, I remember staff saying, well, does that mean anything goes now? Can people do anything, and because we're saying we've got just culture, we learn about everything. And that's not the case, because we draw clear lines of accountability. But in this sense, we're trying to get people to be honest and candourous in giving their account of the event. So that's telling it 100% how an incident occurred.

So the true accountability is telling the scenario fully. And in our experience, what was happening was staff didn't feel comfortable or safe or confident to give the full account of what actually occurred. And in that time, that created a brick wall, a brick wall between employer and employee, a brick wall between individuals and teams or team members and team members, or indeed a brick wall between patients and staff, or patients, staff and families.

Because people got that sense that the full account wasn't truly being given, and of course, if only half a story is being shared, only half the learning is being gathered, or the learning could be inhibited because the full extent of the story isn’t being shared.

So it's not about being blame-free or anything goes. We expect accountability, and indeed what we would say in our experience, reporting of incidents has increased, but the harm level is reduced as a consequence of people feeling safer to give the genuine account.

And you know, it's something that's really important about distinguishing between causation and contribution. Often in health, it's very, very easy to put an individual in the frame. So, Amanda caused the harm of this patient or that other member of staff by her actions. But it's very, very rare that it's a one-on-one scenario.

There's more likely contributory factors, and they can be, you know, training, education, staffing level, resources available, so many things as well as individual fallibility. The other thing to consider is the imagination that we've got in senior leadership's positions that all the work that happens on the ground is how we imagine it to occur.

In health, we tend to have hundreds of policies, lots of rules that are far too complicated for people to navigate around or for people to remember in that crisis or immediate response scenario. So what we have to think about is how we distinguish between the work that goes on, on the ground and the work that we imagine people to do when we're running an organisation.

Because we imagine everyone follows all these hundreds of policies, all these rules in every interaction in patient life. But that's probably a really naive reflection. So it's really important to stream your policies down. Make sure they reflect as close as possible the work that happens on the ground and make sure that learning is fostered and that we can try and close the gap between the work that's imagined to the work that's done.

And if we do that, that creates a safety dividend. And really constantly looking forward rather than looking back. So rather than looking back and saying Amanda did something wrong, so Amanda now owes the organisation or has to be sanctioned because she did something wrong, how can we use that as an opportunity for reflection, understanding and learning to ensure the same thing isn't repeated again?

And something that Joe always says is about always ask about “what” and “how,” not “who.” Because “who” will — because “who” will always be beaten in a bad system. And we've got to remember that we are human beings. We're fallible. We will make mistakes.

Joe, over to you.

[Joe] Thanks, Amanda. So, Amanda's laid out really, the sort of notion and principles that we, I think very helpfully, got into our heads in terms of what we would like to do and develop. And after this slide, Amanda will talk about actually the hard bit, the really hard bit, which is how you turn the concepts and the good thinking into a set of practices, which was a big challenge, actually, that we set ourselves.

But it's probably just worth at this point saying that one of the other things we then really begun to think about was what are the conditions for creating organisational success? Because it felt like with the notion of restorative just culture, this was a very, very powerful driver for us beginning to think differently about how to create the context and the organisation to do significant change.

And it's worth saying that we'd really begun then to shift our thinking into our consideration and concern for organisational health not just organisational performance. So if you think about organisational performance, the sort of setting of targets, sometimes actually targets that are not set by the organisation but in our instance by outside regulators very often, and all of those key performance indicators that the organisation drives itself towards, versus a context where we consider the organisational health, where both the health of the organisation and individuals, the well-being and the flourishing of the workforce is something that we really, really take seriously.

So, we thought very hard about our considerations around, you know, are we asking our staff? Can our staff really engage in the organisational mission around the BHAGs and so on? Because do we have enough internal alignment? So, Amanda talked about all of those policies and so on.

Do those make sense in the context, not just of the performance of the organisation, but the health of the organisation, so, direction, leadership, motivation of staff? If people are aligned around what the organisational sort of momentum is, do they really — have we done everything possible to ensure that people have got the ability to execute that change?

Capability, capacity. Are there, as Amanda has said, accountability frameworks that make sense rather than feel like they're very sharp edges that people can fall on. And finally, are we able to — in a very complex health care environment of the type we operate in, can we keep reinventing ourselves in a way that makes sense to the staff who run services every day?

So have we got an appropriate focus on research and development, innovation and learning and so on? So for us, you know, the organisational health has really become as important as organisational performance, and you know, this was one of the critical pieces of learning that came for us.

But sat inside all that organisational health, I think, we ended up very quickly sublimating that down to a sort of critical question, which is do our staff actually feel psychologically safe enough to do all of this complex stuff that we're talking about?

And the purpose of organisational health has principally and predominantly to help deliver the notion of psychological safety.

So Amanda's going to pick that point up now.

[Amanda] Thanks, Joe. So you asked for ten top tips, or five, sorry, five top tips in terms of what would we share with you for you to reflect?

And absolutely, psychological safety is one of them.

We really struggled to get five. That's why I slipped up and said ten. We could give so many. But Joe’s right. I think the bedrock of everything that we do was how do you build psychological safety within teams? And you know, as it articulates, psychological safety is the belief that you will be punished or humiliated or rejected if you ask something that somebody else wouldn’t ask or you speak up.

So you might offer and some words of wisdom — It might be seen as criticising. It might be seen as sharing the mistake — without feeling that you're going to be victimised, punished or laughed at, really.

And so the wonderful work of Amy Edmondson is a key foundation for the research that we've looked at. The only thing we would point out with this is our learning with just culture — so you're kind of getting two tips in one here — has really showed us that language is important.

So we don't use the word, or we try to avoid using the word “failures” or “violations,” because if I said to you, “How did you fail that? How did you make that mistake? Why was that wrong?” that immediately sends a fear in you.

So if I was to explain, can you explain to me, Amanda, something didn't go as planned or expected, that's a different sort of context [—] the introduction to our conversation. And our reflection is that opens a different dialogue with our staff.

So just bear with me… the second tip is to have a framework. We introduced our four step framework back in 2019, so we've been running this for a number of years now. And even though we're in our seventh year of our journey at Mersey Care, we only introduced this a couple of years ago.

And that was really because we certainly sensed that our staff and our union colleagues and our operational managers, as well as my professional HR and OD teams, really wanted a framework, but we didn't want the traditional incident decision tree that put Amanda through something.

So we looked at what we could do to avoid there becoming that framework. So our intent in our gateway process or our framework process is to avoid having to put anybody through any form of formal investigation.

That doesn't mean there's any — there's no learning goal, no reflections or no reviews, but it's to avoid it. So when I said to you before is to stop — you don't need restoration if you haven't damaged something at the beginning. And that's — this is what our framework is attempting to do.

So it very much attempts to look at an incident or event in the workplace and try and understand it and sense make it from the people who were in that event not what you think it was like or what they should have done, because there’s so much bias involved in that. I mean, the killer question for me is always, does it make sense for Amanda, or did it make sense for Amanda for that to occur in that scenario, in that context, on that day?

So it's that sense making, and that really supports our ambitions, both for our staff and our service users. Our third tip is that bit that Joe talked about, and I love this slide, because it kind of really depicts what you think you design and everyone's going to follow to the letter doesn't happen in experience, because people find ways to bypass rules that they don't believe that work in practice.

And if you get that, the user experience can design a new rule that everybody follows, and it becomes the customer practice on the ground. But the design in clinical scenarios may be critical for safety.

But if there's lots of designs that don't work in practice, if people think that they're silly and they don’t make sense, and they’re finding ways around it, they could pick exactly the same scenario for something that's absolutely critical.

So it's really important that your users are there in the design. So it's no good to design something at the top of a tree, you know, the top of a hierarchy without involving the people who are using that and always learning and always refreshing So the closer that alignment, the better the dividend, safety dividend, for staff and for patients.

Our fourth tip is that distinguishing between causality and contribution. So this is about always thinking about that psychological safety as Joe talked about before and asking the what. Because if you ask the what and think about all the things that are listed in there, it can give you a different aspect of accountability.

It gives real candour, honesty, and reflection debriefs, and actually can lead to both organisational accountability — because let's be honest, sometimes organisations are accountable, and that is the very thing that often in our view got missed before. It was all about what individuals did, not what the organisation was accountable for or hadn't done.

So we've got to have that balance, because if we keep going into who — Is it Amanda? Is it Joe? — that tends to be quite legalistic and punitive in approach and doesn't get the outcome that you want. And actually, in our view, inhibits learning and also inhibits prevention. So it's really good to distinguish between causality and contribution.

And the last point for us in terms of the tips is we spend so much time in our health care settings talking about things that we didn't want to happen. Yet, the majority of things happen brilliantly every day, and we don't often talk about that.

And I guess what Sidney's research is really trying to help us understand is, often the things that go really, really well and the things that don't go so well, the same things occur, but the, their outcomes or the intent is very different. So, take communication.

When something is an unwarranted outcome, communications tends to be poor. When it's a positive outcome, it tends to be really, really strong. So what can we learn from the things that go right and not just always looking at the things that don't go to plan or as expected?

And for us, that's been a critical sort of game changer for us. So when we get together and we have patient safety huddles, we always want to reflect on the positives, not the things that we can learn from, because you can learn and do learn from all those things that go right every day in health care.

So just to sort of summarise the benefits before I hand over to Joe to close off, if we look at our people processes, our investigations have decreased significantly over the years, and our suspensions have decreased.

And at the same time, also, our casework has dropped significantly, and at the same time, our workforce has increased by over 135%. So we've seen a massive reduction in both investigations and suspensions, but at the same time, our workforce has increased significantly.

And the same can be said for our learning and our patient safety reviews. So a completely different way of doing things very much more engaging. But it's really important to say that we still learn today, and not everything goes perfectly today at Mersey Care, but the difference is we're willing to learn from every occasion when it doesn't go as planned or as expected. And that's different to what we were a number of years ago.

The second key benefit is really to reflect on our performance metrics. So at the same time, we're not saying don't think about your performance metrics, but by that concentration of all people's wellbeing and health, through the work we've done for restorative just cultures and all the examples we've given you, we've seen our national performance measures over the last three years increase by about 56% of them being achieved, to the end of the financial year we've just finished to be 92% of those being achieved.

So a massive shift in our national oversight targets in terms of how we're governed as an organisation, how we're regulated and how we're viewed nationally. So over all this period of time, through a number of acquisitions our trust has faced, we've seen a sustained level of performance improvement.

And the other thing is, again, it’s exactly the same for our staff survey metrics, particularly around improving patient and staff safety measures, which we see as a key reason, an outcome of our work on the restorative just cultures. We're above national average, and we're in a performing and improving trajectory year on year, even during the pandemic when, actually, we knew how challenging and how vulnerable our staff felt in those environments, yet our staff told us they still felt safer to report incidences that occurred that weren't acceptable in the workplace even during that pandemic.

And that was improving trajectory, and the fact, equally, that was during a number of acquisitions for the organisation. Over to you, Joe, just to summarise.

[Joe] Thanks, Amanda. So, so a few last thoughts from us. We've focussed quite deliberately, from the very first day of doing this work, on explaining and being clear about the conceptual framework we were operating with, but focussing very much on how you take that into practice.

I mean, I can't really emphasise that enough, because I think certainly in the systems we've been dealing with here in the National Health Service, we often get bombarded by sets of principles in how to get things done, and you can feel palpable frustration sometimes from staff who are looking for the threads into delivery and practice. So, we've been very clear about this. We set ourselves an absolutely sort of laser-like focus on getting the set of practices delivered.

And you know, Amanda has talked about that, and I think if you look on the left hand side, some some big swings for us really in many respects. So we're able to point back and connect the concept with the practices, with the delivery, and that's the sort of reinforcing cycle, you know, a virtuous cycle that we hoped to achieve rather than the vicious one can easily follow with a sort of pure focus on just organisational performance. We, from the very early days, talked about a culture that allows the boss to hear bad news. I think that's really, really important.

If you think back to the doughnut with, you know, the blame doughnut, as I like to call it, that was really hard to hear. I mean, really, really tough to hear. And very interestingly, just about the same time that exercise was carried out in another organisation, a slightly different sort of focus of their health care work, but nonetheless the same process, and actually a very, very similar outcome, and interestingly the board of that organisation decided that, well, you know, it's all perception. We're not bullies. Let's continue to do what we're doing. And I think it was our early belief that you have to be open to hearing bad news.

Hearing stuff that made you reflect back on your own personal accountability is really, really important in this one. So, one of the things Amanda and I always say is, unless people who lead organisations are prepared to a) focus on the practice and b) you know, deal with what emerges as you start to unpick practices and put them back together again then it's probably fairly difficult for this to work well.

Thirdly, a co-production approach in the work that we've talked about today. We have just done this side by side with our union colleagues. In fact, they're set the challenge of seeing changes in terms of disciplinaries, investigations, suspensions, and so on. So in a way, that was their challenge back to us.

And you know, we now continue to develop restorative just culture side by side with the people who use our services, and you know, we've been really encouraged by great work coming out of New Zealand to, you know, now make sure that we extend justice and learning and so on to people who are directly harmed, not just our staff. You know, the big benefit is moving to learning from our routine work, the things we do every day, rather than, you know, constraining this in to the big incidents.

And I think, you know, that's the business that says the business of restorative justice culture never stops. It's a never ending journey in that respect. A really important one is to see your people as solutions and not the problem. I think inadvertently, our systems and processes had very much driven to a default scenario of, the people are always the problem, and in reality relationships were the most important thing in stopping all of the stuff that can tumble forward into massive problems for an organisation.

And seeing people as solutions in the context of organisational health is really a big deal here, I think. And finally, sharing your vulnerability. That's the sort of message that both Amanda and I have — both agree on and had to take very seriously, because as senior leaders in a big, complicated organisation with many spotlights on it when incidents do occur and so on, the notion of being able to role model your own vulnerability and think about that and talk about it in a — in the concept of clearly making available as a role model to other leaders in the organisation, your own personal learning cycle that you're going through, your own prospective accountability if you want to phrase it that way, then that's a tremendous opportunity to, I think, send signals about the authenticity of the approach we're trying to take here.

Because, I mean, Amanda and I were very clear with Sidney that all the way through this and still to this very day, staff test the authenticity of what we say, but more than anything, they test the authenticity of what we do in connection to what we say. And keeping that line of integrity and authenticity is very, very important.

So, look, that's the end of our presentation, and I hope you've enjoyed it.

Thank you.