NHS England

Improving Patient Safety Culture

A practical guide

In association with

The **AHSN** *Network*

Foreword

Dr Matt Hill, National Clinical Advisor, NHS England

Safety culture can seem nebulous and it can be unclear how to improve it or indeed how the shift occurs. This has led to a broad number of approaches which are associated with improvements in safety culture but are not always successful when they are used in similar or different contexts.

In considering the safety culture of where we work we often separate out 'what' work we do from 'how' we work. This can lead to a disconnect and lead to 'how' we work not transferring into the 'what' we do.

By considering the 'what' and the 'how' as two intertwined threads where each is necessary to provide a strong team, we can see that unless we give them equal attention the overall strength of it will weaken.

We hope that this 'toolkit' will give teams an understanding of how to craft, create and nurture a positive safety culture and provide a theoretical underpinning to how to shift the culture.

This is the first in a series of safety culture toolkit pieces. We are still learning how to do this, and we invite you to share your experiences of using the toolkit and share what has or hasn't worked, but most importantly share the 'how' of what has made a difference in your teams. This will shape the future work.

We want to work with you to shape this 'toolkit' and to learn together to understand how we can make positive changes to our NHS culture.

Preface

Professor Suzette Woodward

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The toolkit is not a recipe, rather a menu of ingredients and a toolbox to help the reader create a personalised strategy. Like any recipe there are some ingredients that provide the foundation for the rest; a positive approach to safety, a restorative just culture, psychological safety, inclusivity and civility.

Each of these while important on their own when combined can help build the momentum we are seeking, and to spread a positive patient safety culture throughout the national health service.

This toolkit will help you get on the front foot, learn from what works and what doesn't and be far more proactive. Desmond Tutu is quoted as saying 'there comes a point where we need to stop just pulling people out of the river. Some of us need to go upstream and find out why they are falling in'. This toolkit will help you do just that.

Professor Suzette Woodward

Introduction

1. Introduction

Safety culture has been a key and recurring theme in reports where there has been poor care (Francis Report; Morecambe Bay; and Ockenden Report). Its importance highlighted in responses (Berwick Review; and Response to Winterbourne View.

It's ubiquity has hampered our understanding of what it is, and it has become apparent that it means different things to different people, and at different hierarchical levels. Without a common understanding of what we perceive safety culture to be, it is difficult to understand how to create a positive shift.

The nebulous nature of culture and focusing on where the culture is less positive have not allowed us to consider what we are trying to achieve in focusing on it.

Taking an appreciative approach:

"A positive safety culture is one where the environment is collaboratively crafted, created and nurtured so that everybody (individuals, teams, patients, service users, families and carers) can flourish to ensure brilliant safe care."

Prof Seligman on PERMA – YouTube

The NHS Patient Safety Strategy starts to explore how culture is crafted where the "importance of individuals day-to-day behaviour" and how we interact with each other in the moment is increasingly recognised as creating the local culture. These local relational interactions are complex and we do not routinely consider how we are working alongside what work we are doing. Understanding the complexity in these interactions and considering culture as a dynamic social construct can give us useful insight into how interventions which are associated with improvement in culture have their effect, and why they may not work in different contexts.

How does culture shift?

Seeing culture as a dynamic social construct focuses our attention on to our interactions with those in our team and other teams. This emphasises the importance of how we create the space to optimise the relational aspects of the work. In structured parts of work we have traditionally focused on, and measured, process metrics e.g. that teams are meeting, who is there and how long it takes, and not considered the quality of how we work together. It is often only when outcomes are poor or relationships break down that we try to understand how a team is working together.

When we consider how we can influence these social interactions and amplify the relational opportunities there are three elements:

Space/time: We need to create time for teams to come together. These may be structured parts of the working day (eg briefings, huddles, ward rounds) or more informal (e.g. coffee room, corridor conversations, cafe).

What we talk about: We will pay attention to the aspects of work that we talk about and in doing so, what we value becomes explicit. By focusing on the balance between how we ensure brilliant and safe care and what the individuals and team need to flourish allows team to consider how work is sustainable. There is a ripple effect from these conversations into others as teams make sense of their work.

How we talk and work together: The "values based enactment" of how we speak and behave to each other is crucial in crafting the conditions where we can all flourish and ensure brilliant care. To do this, we need to routinely reflect as a team on how we are working together, and invite and value the perspectives of others within the team to understand how each of us feels and the impact that our behaviour has on others. In doing so we can create the conditions where we all feel included, invited to contribute, safe to speak up and that our contributions will be explicitly valued and appreciated.

Recent research by Dr Nicola Mackintosh et al found that the:

"Fidelity of function of interventions is linked as much to the supporting social structures as the form of the intervention itself."

This focuses our thoughts on the social connectedness, peer learning and the importance of the relations between members.

As you use the tools within this toolkit we encourage you to focus on 'how' the practices and interventions are done and consider the relational elements of the work and the extent to which they embody positive values, alongside the practices and interventions that you use in your teams.

The key elements of a positive safety culture

2. What are the key elements of positive safety culture?

All of these are valuable approaches to shifting the culture but we are starting the toolkit with those in red.

We explore how we can craft, create and nurture the conditions to support the key elements of a positive safety culture:

Individuals and team flourishing	Brilliant, safe care and experience
Leadership	Continuous learning and improvement
Teamwork	Safety I & Safety II
Communication	Learning from Excellence
Just Culture	National Patient Safety Improvement Programmes
Psychological safety	Appreciative inquiry
Promoting inclusive behaviours	Patient centred collaboration
Staff well being	
Civility	
Organisational Development	

Teamwork and communication

3. Teamwork and communication

What is it?

Teamwork in healthcare can be thought of as two or more people interacting to deliver safe, high quality care, wherever that is be it in primary care, social care, mental health or acute hospitals. Good communication is essential to this. It should be open, respectful, honest, two-way and inclusive across disciplines and professional groups. Good communication is also about curiosity and seeking to understand the perspectives of others.

Why is it important?

A breakdown in communication between healthcare staff has been identified as the most common cause of safety problems. When communication in teams is poor, it's easy to feel your colleagues are being uncooperative, that your voice isn't being heard, and that you aren't being valued. But when teamwork and communication is good, you feel that you're listened to and that concerns you raise about safety are quickly dealt with. Team members feel motivated and empowered to put forward safety ideas to the team and get them sorted.

What does good look like?

Professor Amy Edmondson has studied what "good" looks like when people come together to work as a team, often for the first time. She calls this 'teaming' and describes four steps to do it well (see Top Tips below), which are particularly helpful if you're working in constantly changing teams. The approach helps break down silos and creates opportunities to develop new solutions for complex problems.

TOP TIPS:

Working together as a team

Adapted from *Extreme Teaming: How to Deliver Integrated Care*

Aim high: set a clear, ambitious, compelling, meaningful vision which inspires people by focusing on the things that matter to the team

Team up: value the diversity of the team as this will lead to a greater ability to achieve breakthroughs

Fail well: identify opportunities for intelligent failures that provide information on how to improve approaches and systems next time round

Learn fast: maximise learning from mistakes – apply focus, discipline and structure when reviewing them.

TOP TIPS:

Safety culture discussion cards

Having informal conversations with colleagues about safety and risk within services is a great place to start. The NHS Scotland safety culture discussion cards, originally developed by Steven Shorrock, are a great resource.

Remember, receiving feedback is hard for anyone if it feels negative. Taking a positive approach to giving feedback to colleagues, delivered empathetically, helps to reduce anxiety and contributes to a continuous learning cycle.

Taking a structured approach to the communication of safety-critical information (tools such as SBAR – the Situation, Background, Assessment, Recommendation) in specific circumstances can be helpful, but imposing a structure in all circumstances may not always be the right approach.

Approaches like safety huddles – regularly scheduled, short meetings to discuss safety – can be an effective way to communicate key information, improve cohesion, build relationships and reinforce shared values and purpose.

CASE STUDY:

Huddling up for safer healthcare – Yorkshire and Humber AHSN

Yorkshire and Humber Patient Safety Collaborative's 'Huddle Up for Safer Healthcare' (HUSH) programme supports and coaches frontline teams to implement safety huddles and deliver sustained improvements in care.

A safety huddle is a short, multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.

The original HUSH focus was falls prevention, and has stopped more than 6,000 falls happening, equating to an estimated £15m in avoided healthcare costs.

However, from its work helping teams address their safety priorities, the Patient Safety Collaborative now has evidence of effectiveness in addressing pressure ulcers, deteriorating patients, nutrition and hydration; and for mental health teams, seclusion, self-harm and violence and aggression.

Read more about safety huddles in Yorkshire and Humber here.

TOP TIPS:

Conducting safety huddles

Taken from the Culture Change Toolbox:

- **Identify a team or small group of staff that is willing to try something new.** Host a trial safety huddle during one shift.
- **Start by explaining the purpose of the huddle.** Consider how we optimise care by discussing safety concerns of the past, present and future and examples of excellent care as well. Emphasise that it's about learning and improving safety, not about blame.
- **Think about some example issues to bring up at the first huddle.** At first, it might not be clear to everyone what sort of topics they can talk about.
- **Keep it short.** Five minutes is reasonable.
- **Thank everyone for their participation and be clear about next steps.** Will someone follow up on the issues raised? Will there be another huddle? What changes can we make to the structure of the huddle to make it more effective?
- **Adjust the structure of the huddle using this first group,** then expand to have them more often or with more staff. Aim to include all team members eventually and determine how often you would like to hold safety huddles in your work area.
- **Be transparent with follow-up.** Share the outcomes of the huddle using email, meetings, posters or personal conversations. Acting on the information shared during safety huddles sends a powerful message that safety matters.
- **Invite other team members to host them** once the huddles happen regularly, so that they can take place without requiring the original facilitator.

Three change ideas to try:

1 Use structured feedback:

Space/time: This can be done throughout our work and can be very quick to do, and have a big effect. Especially if it is positive feedback that is being shared.

What: Feedback is a key ingredient of the learning cycle. Give each other positive feedback, and the reasons why. Use a structured approach to giving constructive feedback, such as the Situation, Behaviour, Impact (SBI) approach:

eg **Situation:** 'When you were with that patient/relative/colleague in the……. ' This needs to be a specific context.
Behaviour: 'I noticed that you did….. ' This needs to describe what you observed without being judgemental.
Impact: 'It had a real impact on me and made me feel… '
'I noticed how the patient/relative/colleague responded to you and I noticed that they did……..'

How: Think kindly about the other person and, with respect and care, give them a clear description of what you observed at each stage of the feedback.

2

Teach or treat: This is from the Each Baby Counts group

Space/time: These learning conversations can occur at any time when clinical concerns are escalated or another opinion is sought.

What: When a concern about a patient/service user is raised the response form the senior member of staff is framed as either Teach or Treat. If the senior member of staff is happy with the current management then they can respectfully explain their rationale so that each is clear about the other's perceptions. If they believe that new treatment is required then this can be taken in a timely fashion.

How: This encourages staff to have a 'respectful, learning conversation' at times of escalation. This flattens the hierarchy and supports team members to feel that they have been heard and their contribution valued. This helps to support learning and mutual trust through enhanced relationships.

3

Initiate safety huddles

Use resources including the "Yorkshire Safety Huddles Manual" to initiate safety huddles, starting with a single team.

Space: create a time in the day when safety huddles can occur.

What: Any aspect that affects safety can be discussed by understand the importance of the conversation in developing the social relationships between team members.

How: Starting with everyone introducing themselves (even if we think we know everyone) flattens the social hierarchy and makes it more likely that everyone will feel able to speak later and contribute to the duffle and allow all forms of expertise to be valued and heard.

Read about the Innovation Agency's Coaching for Culture programme, which included accredited coaching training for team leaders, use of a team culture diagnostic, and use of practical QI skills to support the development of safe, high-quality, and compassionate services in the North West.

Just and restorative culture

4. Just and restorative culture

What is it?

A just culture is about creating a culture of fairness, transparency and learning. It recognises that success or mistakes are the product of many factors and focuses on changing systems and processes to make it easier for people to do their jobs safely. It is about ensuring everyone is confident they will be treated fairly when something goes wrong.

Why is it important?

NHS Resolution develop this idea further by saying that "What we need is a restorative just culture (Dekker, 2018) that is about repairing and building trust and relationships when things have not gone as planned. This means we need to develop working practices that move people away from fear and blame, including tackling incivility and bullying, and addressing the health and wellbeing needs for staff to help them work safely., Ensure everyone's needs are met, no matter who they are. Treat everyone fairly, no matter what their background is, and help them speak up." (Being Fair, NHS Resolution)

Sydney Dekker described a restorative culture as one that looks to the future by exploring what needs to be done and who should do it. There are three questions:

1: Who is hurt? | 2: What do they need? | 3: Whose obligation is that?

"A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability."

Being Fair, NHS Resolution

Underpinning this approach are the practical applications taken in Being Open and the subsequent Duty of Candour publications.

Shifting to this approach is not just about using the NHS Just Culture Guide but is a wholesale shift of approach, supported by the Patient Safety Incident Response Framework (PSIRF), but is about "a system designed for safety and learning rather than performance management". (PSIRF)

Importantly it is recognised in PSIRF that the NHS Just Culture Guide is:
"used only when there is reason to believe the deliberately malicious, negligent or incompetent actions or decisions of an individual contributed to an incident, and not routinely whenever an incident is reported or a Patient Safety Incident Investigation is conducted managed completely separately from any activity to examine an incident for the purposes of learning and improvement led by a colleague of appropriate seniority and with relevant human resources, individual management review or fitness to practise investigation training.

The use of the NHS Just Culture Guide in these situations will also help to "reduce the role of unconscious bias when making decisions and will help ensure all individuals are treated equally and fairly no matter what their staff group, profession or background. This has similarities with the approach being taken by a number of NHS trusts to reduce disproportionate disciplinary action against black, Asian and minority ethnic staff.

CASE STUDY:

Duty of candour community of practice – Health Innovation Network South London

Duty of candour is a statutory requirement in the NHS when a patient experiences harm while receiving healthcare. It ensures patients and staff understand how things may have gone wrong and reassures everyone involved that lessons have been learned.

The Health Innovation Network South London created a community of practice (CoP) to support staff to share and learn best practice when dealing with difficult situations. The community brings clinicians, managers and patient groups together. It has created a set of generic training materials that are used across the area, promoting consistency and tackling difficult aspects of Duty of Candour, such as how practitioners say sorry to patients when things go wrong.

The CoP is still going strong and has proved an effective forum for sharing concerns and making decisions. There is a genuine passion from the professionals who attend about sharing their experiences and effecting positive change within their organisations.
Find out more information here.

CASE STUDY:

Supporting team health: A simple framework and a tale of three teams

Jo Davidson, Associate Director Organisational Effectiveness and Learning and
Melissa Holt, Strategic Organisational Effectiveness Lead

Overview

More than two years responding to COVID has reinforced the significance that great teamwork has on both staff wellbeing and the safety, quality and experience of care they provide. NHS organisations are full of people caring for others but what happens when those teams, become stuck in conflict, toxicity or resistance to change? These sorts of comments are not common to any one organisation, the experiences by these teams are all to common across the health service.

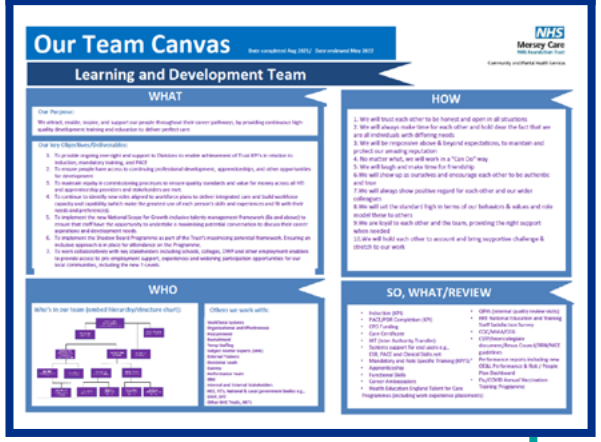
This piece tells the story of three such teams, brought back to health with the use of a simple tool - The Mersey Care "Team Canvas", and how that tool has been used to facilitate team health and culture across the Trust. It includes how it has been designed and implemented to integrate with our clinical assessment, improvement and accreditation processes which enables us to track and measure improvement and demonstrate the impact not just to our colleagues, but importantly to our patients.

This excerpt provides detail in relation to just one of the OD interventions that have been designed and developed to support a Restorative, Just and Learning Culture at Mersey Care NHSFT, all of which are described within the recent publication of 'Restorative, Just Culture in Practice'.

"Managers don't trust us, we're closest to the patients and yet when we put ideas forward, no one listens, we're the bottom of the pile" **Team A**

"In this team I've lost my confidence and any sense of feeling valuable or valued" **Team B**

"Changes are not discussed. They are dictated, regimented and we are told - not asked" **Team C**



Three change ideas to try:

1 Consider how to adapt and use the Just and Learning Culture Charter in NHS Resolution 'Being Fair':

Space/time: Use a team meeting to discuss what a just and learning culture means to your team, and what their experiences have been. The shift to a just and learning culture requires a continuous approach that is anchored in the elements of a Just and Learning Culture Charter. The key purposes of transparency, fairness, learning underpinned by the principle that patients and families involved in a patient safety incident need to be looked after and have their questions answered.

What: In the discussion ask what the people's experiences have been when thing have gone wrong and how they felt and how they thought it was for the patient and families. There is a need for a shift in the language that we use and the approach to incidents that focus on the learning – what happened not who was involved.

How: Consider how to involve everyone in the discussion so that all the perspectives are heard and the process supports the principles of openness, honesty and transparency.

Three change ideas to try:

2 Recognise staff as the victims of unsafe systems too:

Staff who are involved in an unanticipated adverse patient event, caused by systemic issues, including human factors, can be traumatised by the event.

Resources to support second victims are available through the Improvement Academy's dedicated Second Victim Support website

3 Use the NHS Just Culture Guide:

This is a way to ensure that everyone is treated fairly in the event of an incident of harm. The NHS Just Culture Guide is a tool to support individuals to treat staff fairly, consistently and constructively if they have been involved in a patient safetyincident and to help to prevent unconscious biases.

Psychological safety

5. Psychological safety

Psychological safety was first described by Amy Edmondson who defined it as:

"A shared belief held by members of a team that the team is safe for interpersonal risk taking."

It describes the ability of members of a group to feel free to speak up, ask questions, report errors, raise concerns and ask for feedback without fearing the consequences and being judged. We learn early in life about making mistakes and the feelings of embarrassment and awkwardness it provokes. As adults we naturally avoid these awkward situations. When discussing safety, it's important to create conditions in which we feel safe to take what can feels like personal risk, saying for example, "I made a mistake" or 'this didn't go as planned", without fear of judgement.

Psychological safety in a team does not happen by chance – it needs to be actively created and nurtured. The feeling of inclusivity and trust are key to crafting the conditions where diversity of thought in ethnicity, gender and age is welcomed and valued as it leads to a more complete picture and better care.

It does not mean that we will always agree and that teams will be free from conflict, but that by feeling valued we can all contribute our ideas to a find a better solution.

In the book *The Four Stages of Psychological Safety*, Timothy Clarke describes how teams move through each stage:

Stage 1 Inclusion Safety: Team members, whatever their age, sexuality, ethnicity or colour, feel that they are included and valued and that they are appreciated by the team.
Stage 2 Learner Safety: Team members are able to admit that they don't know things and are able to ask questions and start to try new things.
Stage 3 Contributor Safety: Team members are able to voice their own ideas without fear of being ridiculed or embarrassed.
Stage 4 Challenger Safety: Team members are able to question the thoughts of others in the team including those with power.

In 'The Fearless Organisation', Amy Edmondson describes three ways to help to create psychological safety in healthcare.

	Leadership tasks			Accomplishes
Set the stage	**Frame the work:** • Set expectations about failure, uncertainty and interdependence to clarify the need for voice	**Emphasise purpose:** • Identify what's at stake • Why it matters • For whom it matters		**Shared expectations and meaning**
Inviting participation	**Demonstrate situational humility:** • Acknowledge gaps	**Practice inquiry:** • Ask good questions • Model intense listening	**Set up structures and processes:** • Create forums for input • Provide guidelines for discussion	**Confidence that voice is welcome**
Responding productively	**Express appreciation:** • Listen • Acknowledge • Thank people	**Destigmatise failure:** • Look forward • Offer help • Discuss, consider and brainstorm next steps	**Sanction clear violations**	**Orientation toward continuous learning**

1. **Try using a survey to measure psychological safety in your team to understand and then discuss the different perceptions within the team.**

2. **Leaders and team members sharing their stories about when things went wrong for them, and what they learnt.**

3. **National Staff Survey results are available on the Model Health System– start a discussion about the team's results.**

Consider using the King's Fund ABC (Autonomy, Belonging and Contribution) Framework which links the questions to these topics. This is a good way to start a conversation about the results

Psychological Safety Survey

1. If you make a mistake in this team, it is often held against you.
2. Members of this team are able to bring up problems and tough issues.
3. People on this team sometimes reject others for being different.
4. It is safe to take a risk on this team.
5. It is difficult to ask other members of this team for help.
6. No one on this team would deliberately act in a way that undermines my efforts.
7. Working with members of this team, my unique skills and talents are valued and utililsed.

Amy Edmondson. The Fearless Organization. Wiley, 2019

Why is it important?

There is strong evidence that where an NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves.

Yet it is also clear that in some parts of the NHS, the way a patient or member of staff looks can determine how they are treated. Undermining, humiliating and discriminating behaviours increase fear and decrease team psychological safety and learning.

Celebrating difference and diversity in all forms stimulates learning and creativity, if harnessed in the right way. Civility between health and care professionals in the work environment matters because it reduces errors and stress and fosters excellence.

Patients, carers and families are in a unique position to provide new ideas and insights and to identify safety and care quality concerns that insiders may have ceased to notice long ago. They may also spot team issues and behaviours that are unsafe.

Promoting diversity inclusive behaviours

6. Promoting diversity inclusive behaviours

What is it?

The NHS People Plan states that:

"The NHS was established on the principles of social justice and equity. In many ways, it is the nation's social conscience, but the treatment of our colleagues from minority groups falls short far too often. Not addressing this limits our collective potential. It prevents the NHS from achieving excellence in healthcare, from identifying and using our best talent, from closing the gap on health inequalities, and from achieving the service changes that are needed to improve population health."

Inclusion is the degree to which a person perceives that they are an esteemed member of the work group through experiencing treatment that satisfies their needs for belongingness and uniqueness. Team environments that promote inclusivity and psychological safety of their members usually achieve the best patient safety outcomes. Such teams model behaviours characterised by civility, inclusivity, trust, respect and professional courtesy. They offer team members the chance to thrive and be themselves and foster diversity, equality and fairness. Such environments value and encourage continuous input from patients, carers and families into the design and delivery of their services.

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Patients, carers and families are in a unique position to provide new ideas and insights and to identify safety and care quality concerns that insiders may have ceased to notice long ago. They may also spot team issues and behaviours that are unsafe.

What does good look like?

Inclusive teams recognise and celebrate diversity and difference both for team members and their patients. Inclusive teams promote equity and fairness for everyone, no matter your ethnicity, age, gender, sexuality, religion or power.

They hunt the good stuff – the things that unite and energise you and which give you shared common purpose.

Diversity of thought is paramount.

Encourage patients, carers and families in all their diversity to be at the centre of your all plans and involved in co-creating them.

Three change ideas to try:

Support staff wellbeing and joy in work
The Institute for Healthcare Improvement (IHI) has developed a range of resources, including a Conversation and Action Guide to support staff wellbeing and joy in work after the COVID-19 pandemic.

Reverse mentoring
It can be difficult to understand how it feels to be different members in a team. By partnering with a more junior member of a team from a different diverse background , a leader can spend time with them to understand the different perceptions that they have and understand 'work as done' rather than 'work as imagined"'.

Always events
Implement the Always Event methodology – aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the system – as a means of consistently putting patients at the heart of the care provided.

CASE STUDY:

Seema Srivastava is a geriatrician and Associate Medical Director at North Bristol NHS Trust. Here she discusses how responding to the COVID-19 pandemic provided an opportunity to engage with Black, Asian and Minority Ethnic staff at the hospital.

One of the most worrying findings in the research and reviews into COVID-19 is how it has disproportionately affected some groups more than others in our society, particularly people from ethnic minority backgrounds. In April, during the height of the pandemic, we realised there was an urgent need to find out how this was affecting staff at North Bristol NHS Trust, particularly those from ethnic minorities (also referred to as from black, Asian and minority ethnic or BAME backgrounds).

We wanted to understand how people were feeling at this time and what we could do to create a space that felt safe, where people felt cared for, and which would build on a safety culture that recognised and addressed this inequality.

Supported by Jackie Marshall, the Trust's Director of People, we arranged a series of virtual listening events to hear from staff from ethnic minorities, listen to their lived experiences and ask what meaningful actions we could take. They were held as open forums for any member of staff, regardless of their role or level in the trust.

We knew that not everyone would be able to attend virtual meetings, so we also ran face-to-face sessions in a large marquee with social distancing in place.

Between April and June, we held 11 events in total and around 240 staff attended, giving rich insight into the issues they were facing. Some staff had been unwell with COVID-19 themselves; others knew friends or family members who had sadly died.

Themes emerging from these events included worries about PPE and access to health risk assessments. This led to immediate improvements, with some of the attendees co-designing an updated risk assessment process, to enable better safety and better conversations between managers and staff. These sessions also coincided with the Black Lives Matter movement, and they became a platform for people to share their feelings and experiences about the impact of racial injustice in their daily lives.

While the trust had held staff engagement events before, it had never attempted something on this scale. As the hospital employs over 9,000 people, they are really important to create safe spaces for listening. The existing BAME network has also increased its membership, and we are contributing to conversations about wellbeing as part of the trust's 'People Strategy'.

We found COVID-19 has brought many existing issues to the surface, but it's also given us the time and permission to address them in a way we haven't before. I hope we can maintain this momentum and build on the framework we've created to ensure a safer culture for staff in future.

Civility

7. Civility

Civility is essential for individuals and teams to fulfil their potential and "civil work environments matter because they reduce errors, reduce stress and foster excellence." It "creates that sense of safety and is a key ingredient of great teams."

The Civility Saves Lives campaign promotes the importance of respect, professional courtesy and valuing each other. The campaign aims to raise awareness of the negative impact that rudeness (incivility) can have in healthcare, so that we can understand the impact of our behaviours. Patients, carers and families notice incivility between team members, which can lead to increased feelings of fear and vulnerability, and a poorer patient experience. The campaign includes examples of how teams have sought to make patients active participants in fostering a positive safety culture.

There is also a NHSE Civility and Respect Toolkit with a number of resources within it to support teams.

Space/time: Add the topic of civility to a team meeting.

What: Use the infographics to start a discussion or watch a video. Discuss what team members experiences of civility and incivility are and how they have felt when these have occurred.

How: Discuss what clear standards and expectations the team have and role model respect and care for others to enable meaningful and respectful connection and participation.

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