Healthcare’s just culture journey:

*a long and winding road*

Martin Bromiley OBE

Chair, Clinical Human Factors Group
Healthcare’s just culture journey:

*Part 1 - Exploring the culture by looking at the symptoms of the culture*
What’s happened since 2005 at the frontline?

• Greater recognition of “safety”
• Use of tools such as checklists
• Use of simulation & CRM training
• Better recognition of non-technical skills
Colleagues/teamwork

Cognitive capacity

Personal stress, alertness, tiredness etc
The context

• In one year 3,283 patients dead through preventable error, in England alone
• ~1 in 10 patients suffer some form of unintended harm
• ~1 in 300 hospital admissions will die as a direct result of error

(Data from Parliamentary Inquiry into Patient Safety 2009 and DH/NAO publications 2005-2009)
“We have a Just Culture, we Just blame whoever did it" - Doctor, Oct 2014
“...families faced delay, denial and obfuscation in their search for the truth” - Secretary of State for Health, RT Hon Jeremy Hunt MP Mar 2015
“My hospital asked a retired Doctor to come back to help them. They've got over 60 investigations outstanding and if they don't get completed soon the Hospital will be in trouble. He'll do a good job but the Board don't care about that, they just want the backlog cleared"

- Consultant, Nov 2016
“I didn’t share mistakes as I was told good nurses don’t make them” - Nurse, 6 Sep 2016
MITIGATE CONSEQUENCES OF ERROR

TRAP ERROR
Procedural complexity increases non-compliance

Carthey et al., 2011. Breaking the rules: understanding non-compliance with policies and procedures
Systemic Migration to Boundaries

Very Unsafe Space

Driving 90+ mph – the ‘illegal-illegal’ space (for almost all of us!)

Driving 80 mph - the ‘Illegal-normal’ space

The posted speed limit is 70 mph - the ‘legal’ space

Life Pressures

Perceived vulnerability

Belief Systems.
Three contrasting approaches to safety

**Ultra adaptive**
Embracing risk

*Context:* Taking risks is the essence of the profession:
Deep sea fishing, military in war time, drilling industry, rare cancer, treatment of trauma.

*Safety model:* **Power to experts**
to rely on personal resilience, expertise and technology to survive and prosper in adverse conditions.

*Training* through peer-to-peer learning shadowing, acquiring professional experience, knowing one’s own limitations.

*Priority to adaptation and recovery strategies*

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**High reliability**
Managing risk

*Context:* Risk is not sought out but is inherent in the profession:
Marine, shipping, oil Industry, fire-fighters, elective surgery.

*Safety model:* **Power to the group** to organise itself, provide mutual protection, apply procedures, adapt, and make sense of the environment.

*Training in teams* to prepare and rehearse flexible routines for the management of hazards.

*Priority to procedures and adaptation strategies*

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**Ultra safe**
Avoiding risk

*Context:* Risk is excluded as far as possible:
Civil aviation, nuclear Industry, public transport, food industry, medical laboratory, blood transfusion.

*Safety model:* **Power to regulators and supervision** of the system to avoid exposing front-line actors to unnecessary risks.

*Training in teams* to apply procedures for both routine operations and emergencies.

*Priority to prevention strategies*

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### Innovative medicine
*Trauma centers*
- Himalaya mountaineering
- Finance
- Forces, war time
- Professional fishing

### Scheduled surgery
*Chronic care*
- Fire fighting
- Drilling industry
- Chemical industry (total)

### Anaesthesiology ASA1
- Chartered flight
- Processing industry

### Radiotherapy
*Blood transfusion*
- Civil aviation
- Railways
- Nuclear industry

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10-2 10-3 10-4 10-5 10-6

**Very unsafe**  **Unsafe**  **Safe**  **Ultra safe**
Healthcare’s just culture journey:

Part 2 - What would a Just Culture look like and achieve for healthcare
“By pinning the blame on individuals, we sometimes duck the bigger challenge of identifying the problems that often lurk in complex systems and which are often the true cause of avoidable harm” - Rt Hon Jeremy Hunt MP, Secretary of State for Health, 3 March 2016
Report of the Expert Advisory Group

Healthcare Safety Investigation Branch
“A just culture depends on establishing a clear distinction between the ‘honest mistakes’ of well intentioned healthcare workers where punitive responses are neither warranted nor helpful; and the rare acts that involve reckless neglect or mistreatment” - EAG report into establishing HSIB, May 2016
Is just culture a thing, a policy, or is it a feeling?
An environment that feels and is better and safer
An environment that feels and is better and safer

Honest, open relationships whatever......
An environment that feels and is better and safer

Honest, open relationships whatever.....

Fairness, a Just Culture policy
An environment that feels and is better and safer

- Honest, open relationships whatever.....
- Fairness, a Just Culture policy
- High quality independent investigation
An environment that feels and is better and safer

- Honest, open relationships whatever.....
- Fairness, a Just Culture policy
- "Protections"
- High quality independent investigation
An environment that feels and is better and safer

Honest, open relationships whatever.....

Science of safety and human factors

Fairness, a Just Culture policy

"Protections"

High quality independent investigation
Leadership by behaviour not word

Fairness, a Just Culture policy

"Protections"

High quality independent investigation

Science of safety and human factors

Honest, open relationships whatever......
We recommend a Just Culture Task Force be established....This should determine the appropriate policies, practice and institutional arrangements that are required to move the healthcare system firmly towards a just culture of safety”

- EAG report into establishing HSIB, May 2016
Thank you

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