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The art of the possible? Supporting a patient safety culture in mental healthcare to maximise safety

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ABSTRACT

Purpose

The current national patient safety strategy for the National Health Service (NHS) in England states that actions need to be taken to support the development of a patient safety culture. This includes that local systems should seek to understand staff perceptions of the fairness and effectiveness of serious incident management. This study aims to explore the perspectives of patient safety professionals about what works well and what could be done better to support a patient safety culture at the level of Trust strategy and serious incident governance.

Approach

A total of 15 professionals with a role in serious incident management, from five mental health Trusts in England, were interviewed using a semi-structured interview guide. Thematic analysis and qualitative description was used to analyse the data.

Findings

Participants felt that actions to support a patient safety culture were challenging and required long-term and clinical commitment. Broadening the scope of serious incident investigations was felt to be one way to better understand patient safety culture issues. Organisational influences during the serious incident management process were highlighted, informing approaches to maximise the fairness and objectivity of investigation findings.

Originality

The findings of this study offer original insights that the NHS safety system can use to facilitate progression of the patient safety culture agenda. In particular, local mental health Trusts could consider the findings in the context of their current strategic objectives related to patient safety culture and operational delivery of serious incident management frameworks.

1 Introduction

Our previous study of the implementation of patient safety policies in the National Health Service (NHS) in England (Wood et al., 2022) included a review of the first patient safety strategy for the NHS, entitled *Building a safer NHS for patients* (Department of Health (DH), 2001). This strategy, in addition to recommending that a process should be developed for building expertise in root cause analysis (RCA) to investigate serious incidents, commented that there was a culture of defensiveness and blame in the NHS associated with the occurrence of serious incidents (DH, 2001). The importance of patient safety culture has been recently re-emphasised in the current patient safety strategy for the NHS in England; it states that the NHS needs to build on patient safety culture as a 'foundation' for safer care (NHSE and NHSI, 2019, p. 4). The case for developing a better understanding of patient safety culture is also supported by a finding in our own study (Wood et al., 2022). The focus of the qualitative study we present here is on the issue of patient safety culture, which uses data derived from parallel discussions with the participants of our previously reported work on the issue of patient safety systems (Wood et al., 2023a).

Patient safety culture is a broad and diffuse concept (Vincent, Burnett and Carthey, 2013), but at its simplest level, it refers to the shared values, beliefs and attitudes about patient safety. It has long been recognised that to improve patient safety in the NHS, it is paramount to create an open culture amongst staff in which serious patient safety incidents are reviewed without fear of punishment and blame (Barach and Small, 2000; Dixon, 2013; Wood et al., 2022). The problem of the 'punishment myth', that staff who make errors will not make them again if they are punished, is highlighted in *The NHS patient safety strategy* (NHSE and NHSI, 2019). This suggests that a 'blame' culture is still a problem in healthcare. Even though serious incidents are rare, clinicians involved in risk-related decisions routinely hold in mind the prospect of being blamed in the event of an imagined future incident (Nathan et al., 2021), which in turn can interfere with their capacity to properly assess risk and maintain a therapeutic stance (Nathan and Bhandari, 2022). Greater effort in shifting towards a 'no blame' culture is therefore required to deliver improvements to patient safety outcomes, including by taking a less reactive approach to serious incidents and instead maximising learning from them (National Audit Office, 2005; Wood et al., 2022).

From the perspective of staff, objectivity, as a good practice principle in delivering serious incident investigations (NHSE, 2015), is one means of delivering fair investigations (NHSE and NHSI, 2019). However, only incremental progress has been made in developing an ingrained patient safety culture in the NHS since the publication of *Building a safer NHS for patients* (DH, 2001; Tingle, 2018). There is a paucity of literature around how to develop a patient safety culture, though it has been reported and recognised that patient safety culture is difficult to measure and assess (Vincent, Burnett and Carthey, 2013) and it

takes time to develop (Thorlby et al., 2014). *The NHS patient safety strategy* recognises that a positive culture requires kindness and civility, but it is limited to recommending the use of existing culture metrics and ensuring that 'just culture' principles are embedded in all patient safety activity, including serious incident investigations (NHSE and NHSI, 2019). The NHS *A just culture guide* advocates the promotion of a psychologically safe working culture, in which serious incident investigations fairly evaluate the relationship between staff involved in patient safety incidents and the systems with which they interacted, known as 'human factors' (NHSE and NHSI, 2021a).

Another problem with advancing patient safety culture is that it requires the right conditions (Flott et al., 2018; Wood et al., 2022). One of the principal patient safety initiatives being implemented across the NHS in England, which will not only have an influence on patient safety culture, but will also require the right conditions within organisations for it to have a positive influence, is that each NHS Trust should employ 'patient safety partners' (PSPs) and provide an effective culture for them. PSPs are patients, carers and other lay people, who should be supported by the NHS Trust's patient safety specialist (PSS) (the dedicated senior patient safety leader) to contribute to the organisation's governance and management processes for patient safety, including supporting serious incident investigations (NHSE and NHSI, 2021b).

Our study aims explore patient safety culture from the perspective of mental health Trust patient safety professionals who have a leading role in serious incident management. This includes seeking their views on understanding patient safety culture in the context of the fairness and effectiveness of serious incident management, which *The NHS patient safety strategy* highlights as an approach that will maximise the identification of learning and continuous improvement (NHSE and NHSI, 2019). It is anticipated that our findings will be an important contribution to the current knowledge base in the field of patient safety, by providing an understanding of how the intent of the current patient strategy for the NHS in England might be interpreted by staff within their local mental health Trust contexts and cultures (Jones, 2018) and therefore what further inquiry might be indicated.

2 Method

This paper reports on the patient safety culture component of our study. The study sample is the same as our study examining patient safety systems (Wood et al., 2023a), but necessary detail concerning the methods is provided here so that this paper can be read on its own and to provide sufficient detail to enable replicability (Leung, 2015). This qualitative interview study aims to build on the findings of our questionnaire study regarding the practice of incident reporting and management (Wood et al., 2023b). Semi-structured interviews were selected as an appropriate method to understand professionals' perspectives about supporting a patient safety culture in local systems, with a particular

focus on improving the effectiveness of serious incident management. These professionals were asked about what works well and what could be done better to support a patient safety culture in their respective organisations, in particular through the serious incident investigation process, as per *Table 1*. The study was approved by The University of Manchester Proportionate Research Ethics Committee (Reference: 2020-10350-16789) and the NHS Health Research Authority (Reference: 20/HRA/6019).

Table 1 Interview guide

Discussion areas concerning the support for a patient safety culture to improve the effectiveness of serious incident management
Introduction to interviews Aims are to understand: ▪ How embedded patient safety culture principles are in patient safety activity, including serious incident investigations ▪ Perspectives about what actions are required to support a patient safety culture, particularly in the context of ensuring fair and effective serious incident management
Topic 1: Influences during serious incident management ▪ Ask about organisational influences during the investigation process (How does this impact on perceptions of the fairness of investigation findings?) ▪ Ask what measures are taken to maximise objectivity of the investigation process (Explore bias as appropriate, specifically the influences of/ on investigators, and the impact of this on investigation findings – ask, can you tell me more?) ▪ Ask about the preparedness for embracing the incoming PSIRF in light of the current organisational culture (What are the challenges? What are the opportunities?)
Topic 2: Patient safety culture ▪ Ask if patient safety culture and psychological safety are reviewed, both at organisational level and as part of the investigation process? (If so, how? If not, why? What would help to do this better?) ▪ Ask about approaches to promoting a patient safety culture (Explore the anticipated impact of the introduction of patient safety partners on patient safety culture) ▪ Ask whether patient safety culture is a priority for boards (Explore if there is an organisational vision for patient safety. Is this aligned to the outputs of serious incident investigations reviewed by the board?)

2.1 *Participants*

The selected sampling approach was purposive, as this approach provides access to particular perspectives on research areas of interest (Smith, Flowers and Larkin, 2022). DW reviewed responses from the precursor questionnaire study (Wood et al., 2023b) and selected Trusts where it was felt that follow-up would provide substantial new insights (Malterud, Siersma and Guassora, 2016). For example, in the questionnaire study, one participant reported that their Trust used a cohort of external investigators to review serious incidents. Therefore, further information on this was relevant, as a contrasting view, to the inquiry of this qualitative study concerning bias associated with the use of in-house investigators.

The final sample included five mental health Trusts, one from each of the following regional boundaries in England: North, Midlands & East, London, South East, and South West. In total, it included fifteen participants across the key three professional groups who are

responsible for the delivery of the serious incident management process. The sample characteristics are detailed in *Table 2*.

Table 2 Interview sample characteristics

Identification code	Occupational title	Sex	Age range (years)	Experience in current role (years)	NHS experience (years)
MGR1	Head of Patient Safety	Male	45–54	10	25
MGR2	Patient Safety Manager	Female	55–64	9	22
MGR3	Patient Safety Specialist	Female	45–54	2	25
MGR4	Head of Patient Safety	Female	35–44	2	10
MGR5	Head of Patient Safety	Male	45–54	7	24
INV1	RCA Lead	Male	45–54	12	21
INV2	Governance Lead	Female	25–34	3	3
INV3	Investigating Manager	Female	55–64	9	31
INV4	Investigating Officer	Female	45–54	7	21
INV5	Lead Investigator	Female	25–34	6	11
DIR1	Director of Nursing	Male	55–64	4	4
DIR2	Director of Nursing	Female	55–64	10	22
DIR3	Director of Nursing	Male	45–54	2	23
DIR4	Chief Nurse	Female	55–64	4	41
DIR5	Director of Nursing	Female	45–54	4	26
			Mean (years)	6	21

2.2 *Interview procedure*

DW conducted all of the one-to-one interviews remotely. The participants were at their place of work. Interviews were semi-structured and followed an interview guide, and ranged from 30 to 102 minutes (mean = 55 minutes). The guide was piloted with three different professionals of a similar designation to the target population. It was also modified in discussion with the other authors. For example, when participants were asked about whether patient safety culture was reviewed as part of the investigation process, prompts further explored if psychological safety was reviewed, as a particular feature of a patient safety culture. This was felt to be an important modification, given the specific reference to psychological safety in *The NHS patient safety strategy* (NHSE and NHSI, 2019). Informed consent of the participants was obtained before interviews commenced and included informing participants that their participation would be kept confidential and that they had the right to withdraw at any time before analysis began. Interviews were video recorded via Microsoft Teams, transcribed verbatim, and anonymised. The data were transferred into and managed in NVivo version 12 (QSR International Pty Ltd, 2018).

2.3 *Analysis procedure*

Analysis was inductive in that it was data-driven, with meaningful themes created and interpreted from the raw data, rather than generated from theory (Braun and Clarke, 2006). A qualitative descriptive approach was used to analyse and present participants' perspectives in language similar to their own accounts (Neergaard et al., 2009).
DW transcribed, read and re-read transcripts as the interviews with each participant progressed, and identified commonalities and differences among the data (Miles,

Huberman and Saldana, 2019) so that data analysis informed later interviews (Department of Health and Social Care, 2020). During the final stages of analysis, DW reviewed the transcripts again to ensure a diverse range of participants' descriptions were presented (Miles, Huberman and Saldana, 2019). Extract examples for each theme were selected based on their representation of the data and to illustrate analytical points (Braun and Clarke, 2006). These quotes are presented in the *Findings*, with numerical identifiers as per *Table 2*. Text in brackets provide explanatory comments; ellipses represent omitted words.

Whilst DW led the analysis procedure, the other authors contributed to this using a 'check and challenge' approach to assure of analytical rigour (Whittemore, Chase and Mandle, 2001; Steinke, 2004). RM read the transcripts in full throughout the data collection process. Throughout the analysis procedure, RM queried the perspectives of DW, given his active professional background allied to the research subject (Kincheloe and McLaren, 2005). This supported ongoing review and refining of the themes. The other authors challenged the interpretations of the data during the analysis and report writing phase of the study (Creswell and Miller, 2000). This rigorous approach supported a shared understanding of the themes that were created and interpreted by DW (Braun and Clarke, 2019). We drew on theoretical frameworks after analysis was complete in considering the implications of the findings.

3 Findings

Three major themes were identified: (1) *Challenges of supporting a patient safety culture* considers reasons for the lack of progress with developing a patient safety culture. (2) *Understanding patient safety culture through serious incident investigations* examines the extent of the assessment of patient safety culture as a line of inquiry during the serious incident investigation process. (3) *Organisational influences during the serious incident management process* examines influences on serious incident investigations and their findings, as well as participants' views on maximising the objectivity of the investigation process to deliver fair and effective investigations. Each of these themes are described and discussed below.

3.1 *Challenges of supporting a patient safety culture*

Consistent with the current national driver, all participants described that supporting a patient safety culture was a priority strategic objective within their respective organisations, for example: 'patient safety culture is in our three-year strategic safety plan' (DIR4). Our analysis attends to participants' views about the difficulty with delivering this priority within their mental health Trust.

3.1.1 *Measurement of patient safety culture*

One of the challenges in supporting the development of a patient safety culture was felt to be the difficulty in being able to measure it. Participants recognised that there were culture metrics in the NHS staff survey, but that these were insufficient to understand the patient safety culture of their organisations, for example: 'the staff survey's weakness is that it doesn't help us understand [patient safety culture]' (DIR1). They felt that the main issue, as described by MGR2, was that: '[patient safety culture is] very subjective', and as such, most Trusts reported they had no definite plans to start measuring and monitoring this component of patient safety. INV1 said: 'we're not there yet, but I think it's increasingly becoming apparent that we need to be better at looking at it'. However, one participant, who was a PSS, was attempting to introduce an anonymous patient safety culture survey of their board members, in line with the recommendation to ensure senior leaders were ready to provide an effective culture for PSPs:

> *It is five questions for [the] board. The intention is to repeat it every six months for three years, because I want to see if the culture of the board changes and by how much as the patient safety partners become integrated. There'll be a lot of data, even from a small minority of people. But it's the top layer of the Trust because it has to start at the top.* (MGR3)

A longer-term approach in order to measure patient safety culture was advocated by participants from the other Trusts, as it was felt that it would enable their organisations to use the data to act in supporting a patient safety culture. For example, MGR4 said: 'I think it will just take time, this is not going to be one year [or] two years, it might be three years until we can get across that feeling that safety is everybody's responsibility'.

3.1.2 *Commitment to taking actions to support a patient safety culture*

Whilst participants felt that their boards saw patient safety culture as a strategic priority, they felt that there was a lack of understanding and clarity around a vision for a patient safety culture.

> *One of our main statements is safe care. Sometimes I don't think the board understand what that means when they've come up with this wonderful vision. Also, they don't see how the culture plays a part in that.* (MGR4)

> *My board colleagues don't want to see high levels of incidents, whereas I always say to them we do want to see high levels of incidents, it's the harm we want to reduce. Things currently are very numbers based. When you're presenting your key performance indicators to board, they see figures. It's my job to help them understand the culture and the ethos of what it should be like. Coming up with visions is fine, but they need to understand what the vision actually means.* (DIR5)

All participants felt that a vision for a patient safety culture, communicated by the Board, was important, despite talking about shortfalls in this area. Actions at operational delivery levels of the organisation were also felt to be important.

> *Outside of the boardroom, we have directorate managers. Effectively, they have the most crucial role. It can't be my role alone. It needs to be that we … have a common language and a common commitment.* (DIR1)

> *I think we are making progress through our clinical leaders. We're talking about it … and we're using the word "safety culture" and "safety is everybody's business". We're repeating that phraseology so people understand that's where we're heading.* (MGR3)

Despite recognition of much needed improvements to patient safety culture, many participants felt that other short-term priorities within their organisations were hindering the pace and scale of progress.

> *I think we have that commitment. But I think in practical terms, probably like many Trusts, it doesn't always translate into real time operational doing, because people are so busy.* (MGR1)

> *When you're dealing day-to-day with people escalating certain things to me, it tells me that the culture isn't quite where it needs to be.* (MGR5)

3.1.3 *Approaches to strengthening incident reporting cultures*

Underlining the commitment to taking actions to support a patient safety culture, and despite the practical challenges in doing so, some participants talked about actions that their Trusts were taking to strengthen their incident reporting culture. MGR4 said that the patient safety team in her Trust had 'been out doing work around … safety culture and no blame and it all being about learning'. When asked about this work, she said:

> *We've introduced safety chats, which are proactive and essentially an opportunity to go out to teams and talk to them informally about safety to really understand that safety culture, what's happening to individuals in their place of work to make them feel safe or unsafe. It's a safety net for people, that they know when they report something, it will get looked after, we will nurture them and make sure they're OK and it's not "blame". Some teams haven't got the culture that we'd want them to have. But, through incident reporting, we hear about them. We go in, we do work, we try to help them to feel safe and supported.* (MGR4)

This and other participants referenced that they were doing work around the foundations for safer care, set out in *The NHS patient safety strategy* (NHSE and NHSI, 2019), regarding the development of a 'just culture' that promotes psychological safety for staff and the promotion of behaviours that support a culture of kindness and civility.

> *There's the hard incident reporting data analysis and where we are seeing trends of no harm and near misses, to ensure we have a good reporting culture and that teams feel safe to report. We're complementing this by doing work on 'just culture', psychological safety, kindness and civility.* (INV4)

> *A few months back, you'd have your debrief section on your incident form and then you … reported what had been done to support staff. But we've done a lot more work on psychological safety and we've got a very committed director who is driving this forward. There will also be instant action if something comes up straight away so that individuals and teams can recover from errors.* (INV5)

3.2 *Understanding patient safety culture through serious incident investigations*

When asked about the interplay between serious incident investigations and the attention on patient safety culture, there was variation amongst Trusts in their use of the investigation process to provide insights into patient safety culture and, in turn, the ability to use this information as an opportunity to identify any required improvement actions.

3.2.1 *Recognition that serious incident investigations can provide insight into patient safety culture*

Most investigators were not routinely using the serious incident investigation process to directly review patient safety culture and so provide recommendations for how culture could be supported. However, they all felt that investigations helped to provide some understanding of a team's patient safety culture, which could be used as an opportunity to promote psychological safety. An exemplar view of this was from INV1, who believed that: 'patient safety culture is not a diagnosis … it's a product of the care we provide; my reviews are an opportunity to understand that culture, but we don't make the best use of that opportunity'. When asked why the opportunity to use investigations to review patient safety culture were not being used, INV1 felt that: 'we've been forced into [using] a checklist ... if it's not on the form, you're not looking at that – as a mental health Trust, you'd think we'd be completely on top of it [because] we should have the best psychologically supported workforce'.

However, some participants felt that, whilst not routinely or directly included in investigation reports, there were examples of the product of serious incident investigations being used to identify issues and actions to support patient safety culture. For example, INV4 said: 'if

there are issues with the team's safety culture, we will then go in and talk about, so it'd be raised as a concern, but not necessarily put in the report'; whilst MGR5 said: 'we do have recommendations where we'll say that there's something here, the safety culture needs looking at'.

Other participants felt that direct or indirect references to issues of patient safety culture would sometimes be identified and presented in investigation reports. It was felt by one participant that the *National patient safety training syllabus* (Academy of Medical Royal Colleges, 2021) would help with identifying issues concerning patient safety culture. Another participant felt that, by starting to increase references to these issues in investigation reports, it was informing where thematic reviews of a team's wider patient safety culture needed attention. However, there was also a reflection on how gaps in understanding of the concepts of human factors and safety culture impacted on the variability in using serious incident investigations to provide insight into patient safety culture.

> *I think some of our … investigators would identify patient safety culture more easily than others. I think that all comes into … human factors training and I think there's more training to be had around that in the organisation. I'm hoping that the national patient safety training will help us with that. So I think with regards to the report, I think that if it was there, it wouldn't be explicit and [investigators] would talk about human factors rather than safety culture.* (MGR 4)

> *We have had particular issues in reports where we have then given a more thematic consideration of safety culture, where we would say: that's our hotspot, that's our place we're worried about.* (MGR1)

3.2.2 *Challenges with including reviews of patient safety culture in serious investigation reports*

Building on the previous sub-theme, and given that participants reported that their investigators were not routinely including reviews of patient safety culture in serious investigation reports, the challenges with this were explored further. Because of the view that patient safety culture was difficult to assess, measure and evidence, a review of patient safety culture in reports of serious incident investigations was largely considered to be inappropriate.

> *Whilst I'm reviewing where patient safety went wrong and clearly why, then our response to that is a measure of our safety culture. But that is as much as I can say really, as we don't use any culture measures. I don't formally assess or comment on culture, but I see it.* (INV2)

I don't think every person would look for [patient safety culture] in an investigation. It would be removed [from the investigation report] because you couldn't evidence it. Culture is very hard to evidence, so you shouldn't be forming opinions in the report. (INV3)

INV3 also felt that references to patient safety culture in serious investigation reports: 'would reflect on the Trust; the Trust would look bad if I put it in'; whilst MGR1 felt that: 'investigations are increasingly, somewhat controversially on occasions, recognising issues around wider safety culture within a team, but I'm not sure it's as well exposed as it might need to be'. DIR1 felt that such contention was because of a tension between a systems approach to safety and patient safety culture being felt to be associated with 'blame', saying: 'national strategy is discouraging identification of individual practice issues, because it's a systems thing, but I think that then lends itself to smoothing over some of the cracks where you think there is a practice issue here'.

3.3 *Organisational influences during the serious incident management process*

The NHS patient safety strategy suggests that to develop a patient safety culture, it requires an understanding of staff perceptions of the fairness and effectiveness of serious incident management (NHSE and NHSI, 2019). Participants were asked about different influences during serious incident management and the impact of this on the fairness and objectivity of investigation findings.

3.3.1 *The influence of investigators on serious incident management*

The subjectivity of investigators was accepted by all participants as an influence on the serious incident management process. From the perspective of an in-house Trust investigator working within a central patient safety team, INV1 had insight into their own influence, but suggested the use of in-house investigators associated with the care team where the incident occurred would result in less effective investigations, saying: 'of course, as investigators, we try to be objective, which is why we don't use service leads to investigate incidents for that very reason, naturally they'd be biased'. The Trust this participant was from also routinely commissioned external investigators whom they did not directly employ, for the purpose of having sufficient investigatory capacity, which was felt by MGR1 to be a further mitigation of investigator bias:

Our internal investigators have a natural bias. They know where all the … difficult spots are. If you take an external investigator, they've got no agenda, they come in, they speak to whoever, they probably get a better result at the end. (MGR1)

When MGR1 was asked about the use of internal and external investigators by their Trust, they felt that: 'external investigators, by definition, are able to be more objective, however, I

think even having the central team who are senior experienced clinicians does still give you that level of objectivity'. INV1 felt that there was a benefit of themself being an internal investigator, compared with the external investigators that their Trust used, saying: 'the fact our investigations take longer might not be a bad thing, as we are really debating the incident'. However, the Trust's director, whilst supportive of the role of internal investigators, felt that external investigators did not confuse their responsibility for undertaking investigations with the accountability that should be held by the director lead for serious incident management:

> *Our internal investigators feel they have a great sense of professional credibility and accountability for the investigations. There is a little bit of tension, because they are very reluctant to change the report in the way that is required because [they believe] they're accountable, and actually they're not. Ultimately, I am, as the director of nursing. This is not the case with external investigators, because they are commissioned.* (DIR1)

Another Trust, who used external investigators less routinely, felt that there were occasions when commissioning investigators outside of the Trust was required to provide assurance of objectivity, with DIR2 acknowledging that: 'we commission investigations that are delivered separately from our Trust in cases where it will be difficult for us to conduct an objective investigation due to its size or the capacity and capability of the individuals involved'.

3.3.2 *The influence on investigators and investigation reports*

Participants acknowledged that, whilst investigators tried to be objective, this was not entirely possible due to organisational influences on them, irrespective of whether their Trust used internal or external investigators. The main influence that was reported by participants appeared to be the board executive director lead for serious incident management, which was acknowledged by this cohort of participants themselves. DIR1 felt that directors should be able to change the investigation report that the investigator had authored, however, they also acknowledged that this introduced bias:

> *Can any Trust, whether they use internal or external reviewers, or both, say they are truly objective or bias free? There's a bias, even with external reviewers [because] we are paying them and I have to be happy with the report. As I sign it off, I can amend it, so I perhaps bring in bias too.* (DIR1)

An investigator reflected on their experience of being asked to amend a report, as part of their organisation's quality assurance process, and how this made them feel:

My last investigation, I had four medical leads and I had to include something a medical lead told me to include. This was disregarded by the team who was responsible for this person's care. So I feel it's all negotiating and trying to get out of [the serious incident investigation process] with your dignity intact. (INV3)

Other investigators talked about how the governance of serious incident management might introduce bias, but also commented on the tensions within their role, which was felt itself to be reflective of the organisation's patient safety culture.

What I have a problem with is when people have fed back to me, because it doesn't fit in with the service, that I change or modify [the investigation report]. Basically, [it's] a culture of "we're just going to do it our own way". The report goes through different levels and individual people with different perspectives and different objectives, wasting time. My last action plan was changed, some of my words were rearranged, but really it didn't add anything, no quality. Because of the current culture, I felt I needed to justify why actions had been included in there – that it came from the relative, or it came from the investigation, or had come from the medical lead. (INV2)

From a governance, rather than experiential point of view, the sign off process – we've got the main group, but we still can lose some objectivity when it goes back to the services because they might want to change something. So you get that battle of, "well, you're only doing that because you've got something invested in it", and yeah, you've got hindsight bias. (INV5)

Some participants felt that influences on the investigation report were a positive intervention that promoted objectivity.

I wouldn't say I'm influenced, rather we get to a consensus, but it has to be acceptable to all, so actually how objective is that? Perhaps it is objective, because if I wasn't challenged, would it be too subjective? (INV1)

We've recruited a drug and alcohol worker. So every report, they are looking at have we answered all those questions around drug and alcohol use. So I think we get a good cross examination. I don't think there's a particular bias in any sense of what we're looking at and excluding. So I'm going with the positive that we look at all aspects. (MGR4)

3.3.3 *Challenges and opportunities in implementing the incoming national incident management framework*

Participants gave contrasting views around whether the *Patient safety incident response framework* (*PSIRF*) (NHSE, 2022) would address the problem of ensuring objectivity, which is a recognised principle to support good patient safety investigation practice. There was concern that introduction of a new framework alone, without additional support, would not improve the effectiveness of serious incident management. However, there was also optimism concerning the introduction of PSPs.

> *Now, throughout the investigation process, and particularly towards the end, people can say – "I want this in" or "I want this taking out". Objectivity and bias is a problem with investigations. I don't think it can be helped, because we're inheriting the old culture, the old style, the old way of investigating and we're trying to make it slot into a new way of working without any real, good training and good support and good focus or good attention.* (MGR3)

> *I think the introduction of patient safety partners will be a big help … they will be our critical friend and will hopefully be very objective with us. So you know, they're going to be key members of the serious incident panel that I chair.* (DIR4)

4 Discussion

The current national driver for the NHS in England, to develop a patient safety culture at a local NHS Trust level, was felt by all participants to be an important component of delivering safer care. Participants identified a number of challenges in advancing this agenda. Patient safety culture was felt to be transient, intractable and difficult to measure. Vincent, Burnett and Carthey (2013), who developed a framework for safety measurement and monitoring across a number of dimensions, reported that safety culture was rarely being used as an assessment in healthcare and that it was not always a reliable marker of safety. Our analysis suggests that the measurement of patient safety culture still poses a problem.

The NHS patient safety strategy recommends the use of existing culture metrics, such as those in the NHS staff survey (NHSE and NHSI, 2019). However, there are more sophisticated tools to help NHS organisations and healthcare teams assess their progress in developing a safety culture, with the *Manchester patient safety framework* having specificity to each NHS Trust type (The University of Manchester, 2006). The lack of adoption of sophisticated tools might be a contributor to little meaningful progress having been made in advancing patient safety culture. The need to allow sufficient implementation time for changes to patient safety culture, as identified by participants of this study, may also have contributed to limited progress. Participants also reported that their boards were

not always providing clear leadership or communicating a compelling vision around patient safety culture, exacerbating the issue. As such, short-term operational issues were being prioritised over long-term actions to support a patient safety culture.

The literature on incident reporting, and particularly the importance of developing a strong incident reporting culture, is more enduring and substantial than that concerning patient safety culture (Reason, 1997). Participants provided examples of their mental health Trusts taking progressive action to advance their incident reporting cultures beyond the promotion of reporting and analysis of all patient safety events and incidents (Vincent, Burnett and Carthey, 2013; Wood et al., 2022). These included implementing initiatives, such as 'safety chats', in order to promote behaviours in the working environment to prioritise learning from patient safety incidents and effecting identified changes to enable care and service delivery improvement.

In contrast to the promotion of incident reporting cultures, understanding patient safety culture issues through the serious incident investigation process was felt to be less developed, despite many participants recognising patient safety culture as a potentially important index of patient safety performance. One of the reasons given for this was related to the aforementioned matter of patient safety culture being difficult to measure, with some perspectives being that reviewing and reporting on values, beliefs and attitudes about patient safety was not the remit of investigations. Another reason was felt to be that reviewing patient safety culture, and subsequently reporting on this, might be associated with blame. A counter argument to this was that not having a focus on patient safety culture was opposite to the aim of creating psychological safety, which it was felt mental health Trusts should be advocating. There were, however, examples of where the output of investigations were subsequently used to inform developmental work concerning a team's patient safety culture. Based on this discussion, future research could evaluate whether the shift towards prioritising a system-based and a 'just culture' approach has any unintended consequences, such as deprioritising attention on addressing problems at the individual practitioner level where this is warranted.

Finally, whilst there is a recognition that creating patient safety systems that are relatively free of bias is complex (Pronovost, Miller and Wachter, 2006), our analysis has highlighted that there are a number of different influences on the serious incident investigation process that could compromise the effectiveness and validity of investigation findings. These influences can be seen as opposite to both candour and the delivery of fair investigation reports, both of which support a more open and fair culture within healthcare (Vincent et al., 2000; NHSE and NHSI, 2019). Our findings suggest that any serious incident management framework will be subject to inherent biases, both on the part of the investigator themselves, people influences on the investigator, and quality assurance mechanisms in

place associated with organisational governance. However, the impact of these influences, in which the final investigation report is the outcome of a process of refinement but is also influenced by negotiation, was seen as both positive and negative. Having an effective ‘group consensus’ model was considered a positive element, namely access to service specific and subject matter expertise and challenge for investigators presenting their findings to the mental health Trust’s oversight and scrutiny group for serious incidents. The negative elements, whereby it was felt that influences had unintended consequences, not only on the integrity of the findings of investigation reports but on the experience for the investigator themselves, could be mitigated and so the aim should be to maximise control measures as far as practicable. Various approaches were suggested by participants in this regard, presented in *Figure 1*, which could be considered by other mental health Trusts.

Figure 1 Principles for maximising the objectivity of serious incident investigations in mental health Trusts

5 Strengths and limitations of this study

Adaptation of new policy by professionals has been previously noted (Wears and Sutcliffe, 2019) when policy is not aligned to professional beliefs (Waring, 2009). Therefore, the engagement of professionals in this research, which is associated with an incoming national policy framework, is considered a strength, as it is more likely that the suggested recommendations, that have been drawn from the findings, can be delivered.

We have sought to demonstrate how broadly our analysis is supported by the data. However, because this study is qualitative, the findings cannot necessarily be generalised, particularly beyond the three occupational groups who were interviewed. There is an opportunity for future research to explore the perspectives of other stakeholders. In doing so, researchers could use other qualitative research techniques and methods appropriate

to the research design and the participant cohorts. These techniques could include focus groups (Green and Thorogood, 2018) or emerging methods such as online interpretative phenomenological analysis (Tanhan, 2020).

6 Conclusions and recommendations

Patient safety culture is a foundation of safer care and an important index of patient safety performance. Our findings suggest that developing patient safety culture requires committed leadership, however this is variable and, at board level, requires attention. We recommend that each mental health Trust should ensure that their Trust strategies have a clear objective that is aligned to the actions to support a patient safety culture, as set out in *The NHS patient safety strategy* (NHSE and NHSI, 2019). Furthermore, the implementation plans for Trust strategies should include clear actions for clinical leaders within the organisation to own and facilitate progression of this agenda.

Despite the recognition of the importance of patient safety culture in both the literature and the findings of this study, identification of initiatives to strengthen patient safety culture have not been as robust as those related to patient safety systems. The current *Serious incident framework* (NHSE, 2015), good practice guidance for serious incident investigations conducted by mental health Trusts (Baker-Glenn and Poole, 2018), standards for investigating serious incidents (National Confidential Inquiry into Suicide and Safety in Mental Health, 2020), and the incoming *PSIRF* (NHSE, 2022), all helpfully provide principles to support good investigation practice. However, a particular and novel finding of our study suggests a number of additional principles, as presented in *Figure 1*, that can be used to maximise the effectiveness of serious incident investigations, by strengthening the objectivity of investigations and their findings. There is, of course, a balance that needs to be achieved when considering that there may be an inverse relationship between objectivity and having a familiarity with services. Thus, approaches that may be considered debiased, such as the use of external investigators, may also suffer from a more limited awareness of the unique aspects of the service in question. Further studies associated with this research topic should therefore consider the perspectives of other occupational and stakeholder groups. This will help to further the understanding of the challenges and potential opportunities for supporting a patient safety culture in mental health Trusts, including so that the delivery of serious incident management can be improved.

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