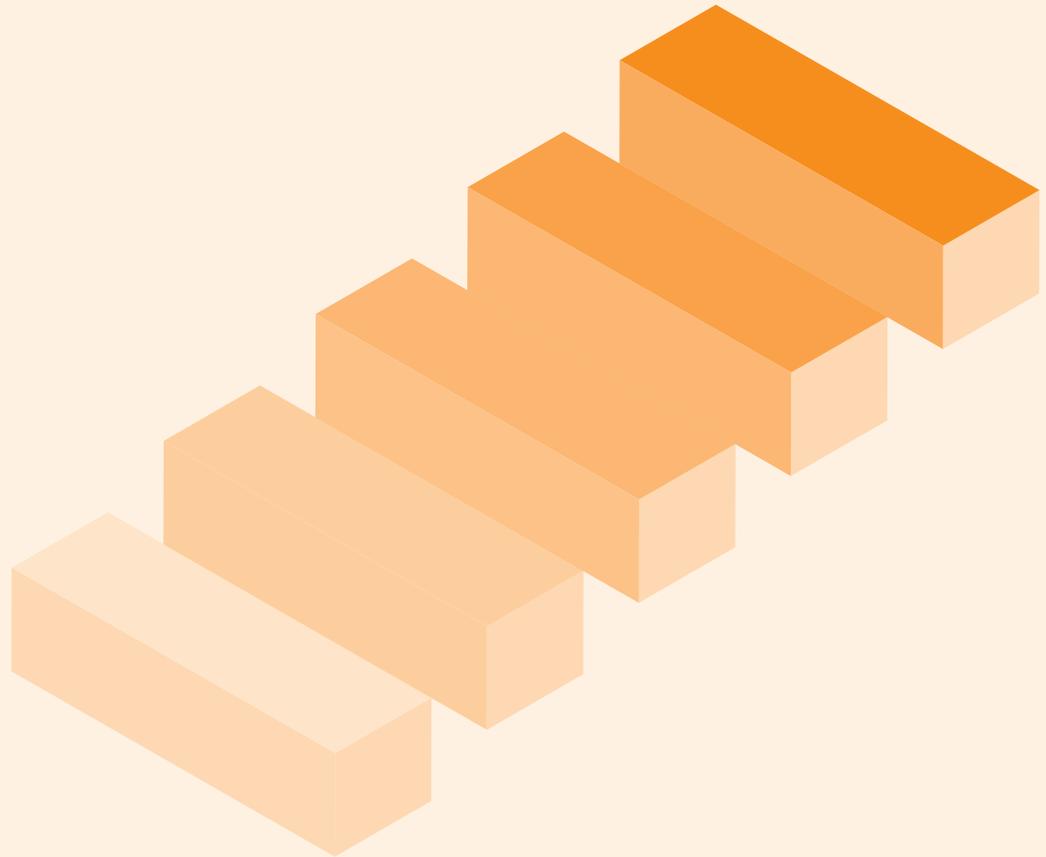# Manchester Patient Safety Framework (MaPSaF)
Primary care

How to use MaPSaF

MaPSaF is best used as a team based self-reflection and educational exercise:

- it should be used by all appropriate members of your team;
- for each of the nine aspects of safety culture, select the description that you think best fits your organisation and/or team.
  Do this individually and privately, without discussion
- use a T (team) or O (organisation) on the evaluation sheet to indicate your choices. If you really can't decide between two of the descriptions, tick both. This will give you an indication of the current patient safety culture profile for your organisation;
- discuss your profiles with the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus;
- consider the overall picture of your organisation and/or team. You will almost certainly notice that the emerging profile is not uniform – that there will be areas where your organisation is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your organisation not more like that? How can you move forward to a higher level?

What we mean by these terms

Patient safety incident (PSI):	Any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded healthcare.
Prevented patient safety incident (PPSI):	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to patients receiving NHS-funded healthcare.
Root cause analysis (RCA):	Is a technique for undertaking a systematic investigation that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. Retrospective and multidisciplinary in its approach, it is designed to identify the sequence of events, working back from the incident.

Evaluation sheet (sample)

Dimension of patient safety culture	A	B	C	D	E
1. Overall commitment to quality					
2. Priority given to patient safety					
3. Perceptions of the causes of PSIs and their identification					
4. Investigating patient safety incidents					
5. Organisational learning following a patient safety incident					
6. Communication about safety issues					
7. Personnel management and safety issues					
8. Staff education and training about safety issues					
9. Team working around safety issues					

T = Team O = Organisation

Manchester Patient Safety Framework (MaPSaF) – Primary care

MaPSaF was originally developed by Dianne Parker, Sue Kirk, Tanya Claridge, Aneez Esmail and Martin Marshall in a collaborative project supported by the National Primary Care Research and Development Centre, University of Manchester. The original idea came from research funded by Shell International.

Why MaPSaF was developed

The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This 'safety culture' is a new concept in the health sector and can be a difficult one to assess and change. This framework has been produced to help make the concept of safety culture more accessible. It was originally designed for use by general practices and primary care organisations and has now been adapted for use in other sectors of healthcare provision to help these organisations to understand their level of development with respect to the value that they place on patient safety. It uses nine dimensions of patient safety and for each of these describes what an organisation would look like at five levels of safety culture. The framework is based on an idea used successfully in non-health sectors. The content is derived from in-depth interviews with a range of primary care health professionals and managers.

MaPSaF is designed to be used to:

- help your team recognise that patient safety is a complex multidimensional concept;
- facilitate reflection on the patient safety culture of a given healthcare organisation and/or team;
- stimulate discussion about the strengths and weaknesses of the patient safety culture in your practice or PCT;
- show up any differences in perception between staff groups;
- help understand how an organisation with a more mature safety culture might look;
- help you evaluate any specific attempt to change the safety culture of your organisation and/or team.

MaPSaF is NOT designed to be used:

- for performance management or assessment purposes;
- to apportion blame when the results show that an organisation's and/or team's safety culture is not sufficiently mature.

MaPSaF and the National Patient Safety Agency (NPSA)

The NPSA has endorsed MaPSaF to help healthcare organisations reflect on their progress in developing a safety culture. The NPSA is not a regulator or a reviewer and the framework has not been developed for this purpose. Rather, it aims to stimulate discussion about the patient safety culture in any given healthcare organisation and in doing so, will help that organisation reflect on its progress towards developing a mature safety culture.

MaPSaF describes in words some of the key elements of an open and fair culture, previously described in the document, *Seven steps to patient safety*. MaPSaF can be used by boards, clinical governance teams, management teams, healthcare teams and others who would like to stop and reflect on their safety culture and risk management processes.

Public and patient involvement

It might seem that patient and public involvement in a maturing risk management culture should be included as a tenth dimension. However, the development of processes to ensure meaningful participation should be seen as being integral to all nine dimensions identified and this is how they have been integrated into the MaPSaF matrix.

The levels of patient safety culture explained

Level	Description
A – Pathological	Why do we need to waste our time on patient safety issues?
B – Reactive	We take patient safety seriously and do something when we have an incident.
C – Bureaucratic	We have systems in place to manage patient safety.
D – Proactive	We are always on the alert/thinking about patient safety issues that might emerge.
E – Generative	Managing patient safety is an integral part of everything we do.

Increasing Maturity
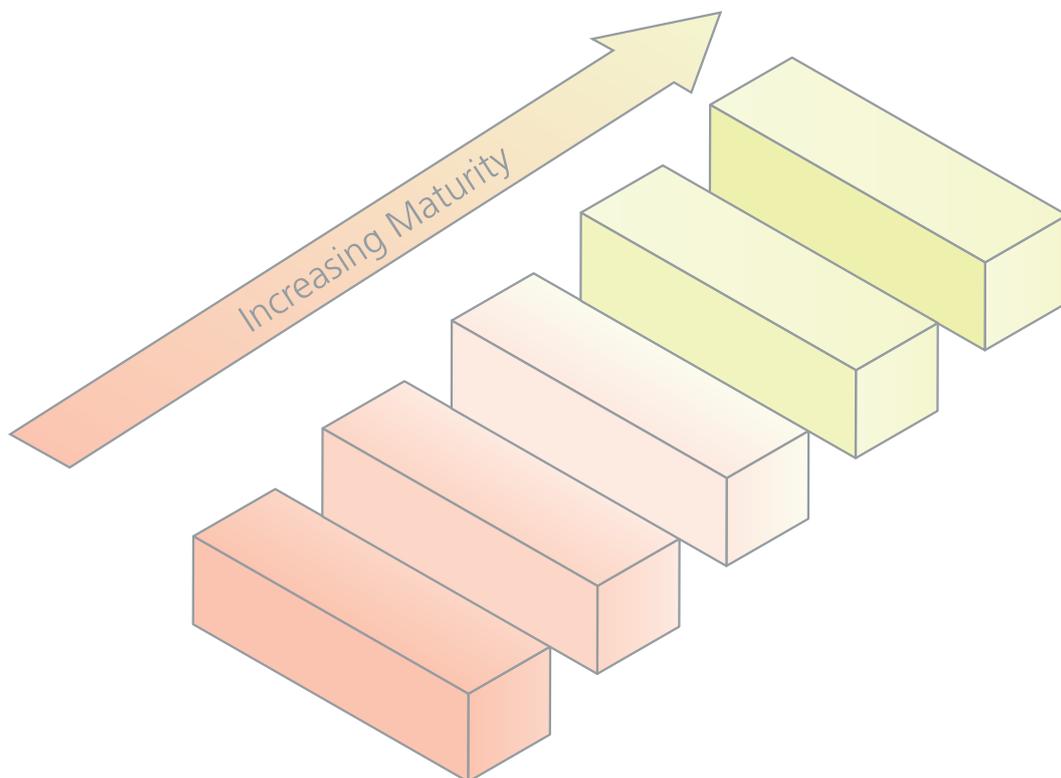
MaPSaF is based on Parker and Hudson's (2001) application of Westrum's (1992) stage model of organisational culture maturity

References
Parker, D and Hudson, P (2001) *Understanding your culture*, Shell International Exploration and Production.
Westrum, R (1992) *Cultures with Requisite Imagination* in Wise, J, Hopkin, D and Stager, P (eds.), *Verification and validation of complex systems: human factors issues* (pp 401–416), Berlin: Springer-Verlag.

MaPSaF explained

How the dimensions were developed

The dimensions are themes that emerged following:

- a literature review about patient safety in primary care and the NHS in general;
- feedback from opinion leaders and interviewees;
- consideration of the dimensions in terms of their comprehensiveness and appropriateness for primary care.

Defining the dimensions

Dimension	Description
1. Overall commitment to quality	How much is invested in developing the quality agenda? What is seen as the main purpose of policies and procedures? What attempts are made to look beyond the organisation for collaboration and innovation?
2. Priority given to patient safety	How seriously is the issue of patient safety taken within the organisation? Where does responsibility lie for patient safety issues?
3. Perceptions of the causes of patient safety incidents and their identification	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed, as an opportunity to blame or improve?
4. Investigating patient safety incidents*	Who investigates incidents and how are they investigated? What is the aim of the organisation? Does the organisation learn from the event?
5. Organisational learning following a patient safety incident	What happens after an incident? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
6. Communication about safety issues	What communication systems are in place? What are their features? What is the quality of record keeping to communicate about safety like?
7. Personnel management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures like?
8. Staff education and training about safety issues	How, why and when are education and training programmes about patient safety developed? What do staff think of them?
9. Team working around safety issues	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

*This term includes incidents that were prevented or which did not lead to harm.

The Manchester Patient Safety Framework (MaPSaF) research team, based at the University of Manchester, includes psychologists, healthcare researchers and healthcare professionals from both primary and acute care settings.

The development of MaPSaF is one part of an ongoing programme of patient safety research that draws on both our expertise working on safety issues in a range of high risk industries, and our extensive research and practical experience in healthcare in the NHS.

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For further information about the National Patient Safety Agency visit:
www.npsa.nhs.uk

Manchester Patient Safety Framework (MaPSaF) – Primary care

Increasing maturity →

		A	B	C	D	E
01.	Overall commitment to quality	There is little commitment to the general quality of care provided or recognition of its importance. This attitude is evidenced at Board level and throughout the organisation in the healthcare teams. Very little time or resources are invested in quality assessment or improvement. If any auditing occurs, it lacks rigour and there is no response to what is discovered. Existing protocols or policies are there to meet the organisation's statutory requirements and are not used, reviewed or updated. Maverick behaviour and poor quality of care is tolerated or ignored.	A quality framework is developed in response to specific directives or an imminent inspection visit. There is no real motivation or enthusiasm for the quality agenda and what occurs is ad hoc, superficial and concerned with 'looking good'. Auditing only occurs in response to specific incidents and national directives and does not reflect local needs. Little attempt is made to respond to any audit findings. The bare minimum of protocols and policies exist and these tend to be out-of-date and unused unless an incident occurs that triggers their review. Development of new protocols and policies occurs in response to incidents and complaints.	There is a defensive attitude towards the quality agenda. The Board and senior managers are motivated by an externally driven agenda and the potential rewards for being seen as quality focused. They are not engaged in the process and they see it as a management activity. Lots of auditing occurs but it lacks an overall strategy linking it with organisational or local needs. Audit findings are only used if there is an incident. Staff are overloaded with protocols and policies (which are regularly reviewed and updated) that are rarely implemented. Patients may be involved in quality issues but this is lip service rather than real engagement.	There is a genuine desire and enthusiasm throughout the organisation to provide high quality care and it is at the forefront of service delivery. There is recognition at Board/senior management level that quality is everyone's responsibility and that the whole organisation, including patients and the public, need to be involved in developing a quality strategy. These organisations aim to be centres of excellence and compare their performance against that of others. Clinicians are involved in the auditing process and have ownership of it. Audit results are used and lead to quality improvements. Protocols and policies are developed and reviewed by staff and are used as the basis for care provision. Patients and the public are formally involved in internal decision making to encourage a patient-centred service.	A quality culture is embedded within the organisation and is integral to all decision making at all levels. The organisation is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Teams and services design and conduct their own audit program, which is outcome focused, in collaboration with patients and the public. In this visionary organisation staff are wary and alert to potential patient safety risks. This may mean that over time there is less need for policies and protocols because patient safety is constantly on everyone's minds. Patients are involved in quality in a routine, meaningful way with ongoing contribution and feedback.
02.	Priority given to patient safety	A low priority is given to patient safety. The few risk management systems that are in place, such as strategies and committees, are tokenistic and nothing is actually delivered. This is a 'chancer' organisation, believing that risks are worth taking and that if a patient safety incident occurs, insurance schemes can be used to bail them out.	Patient safety becomes a priority once an incident occurs but the rest of the time only lip service is paid to the issue apart from meeting legal requirements. There is little evidence of any implementation of a risk management strategy. Safety is only discussed by the Board and/or senior managers in relation to specific incidents. Any measures that are taken are aimed at self-protection and not patient protection. Risks are taken to contain costs.	Patient safety has a fairly high priority and there are numerous systems (including those integrating the patient perspective) in place to protect it. However, these systems are not widely disseminated to staff or reviewed. They also tend to lack the flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Responsibility for risk management is invested in a single individual who does not integrate it within the wider organisation. It is an imposed culture.	Patient safety is promoted throughout the organisation and staff are actively involved in all safety issues and processes. Patients, the public and other organisations are also involved in risk management systems and their review. Measures taken are aimed at patient protection and not self-protection. Risks to patients are identified and action is taken to manage them. There are clear lines of accountability and while one individual takes the lead for patient safety in the organisation, it is a key part of all managers' roles. There is also reporting of patient safety incidents nationally.	Patient safety is integral to the work of the organisation and its staff and is embedded in all activities. Responsibility for safety is seen as being part of everyone's role and this is reflected in individuals' contracts. Staff are constantly assessing risks and looking for potential improvements. Patient safety is a high profile issue throughout all levels of the organisation from the Board through to healthcare teams who have day-to-day contact with patients (including support staff such as administrators, cleaners and technicians). Patient involvement in, and review of, patient safety issues is well-established.
03.	Perceptions of the causes of patient safety incidents and their identification	Incidents are seen as 'bad luck' and outside the organisation's control, occurring as a result of staff errors or patient behaviour. Ad hoc reporting systems are in place but the organisation is largely in 'blissful ignorance' unless serious incidents occur or solicitors' letters are received. Incidents and complaints are 'swept under the carpet' if possible. There is a strong blame culture with individuals subjected to victimisation and disciplinary action.	The organisation sees itself as a victim of circumstances. Individuals are seen as the cause and the solution is retraining and punitive action. There is an embryonic reporting system, although staff are not encouraged to report incidents. Minimum data on the incidents is collected but not analysed. There is a blame culture, so staff are reluctant to report incidents. When incidents occur there is no attempt to support any of those involved, including the patients and their relatives.	There is a recognition that systems contribute to incidents and not just individuals. The organisation says that it has an open and fair culture but it is not perceived in that way by staff. A centralised anonymous reporting system is in place with a lot of emphasis on form completion. Attempts are made to encourage staff and patients/carers to report incidents (including those that did not lead to harm), though staff do not feel safe reporting the latter. The organisation considers other sources of safety information alongside incident reports (e.g. complaints and audits).	It is accepted that incidents are a combination of individual and system faults. Reporting of patient safety incidents, both locally and nationally (for example by using the National Reporting and Learning System), is encouraged and they are seen as learning opportunities. Accessible, 'staff friendly' electronic reporting methods are used, allowing trends to be readily examined. Staff feel safe reporting patient safety incidents. Staff, patients and relatives are involved and supported from the moment of reporting through a being open process. The organisation has an open, fair and collaborative culture.	Organisational failures are noted, although staff are also aware of their own professional accountability in relation to errors. It is second nature for staff to report patient safety incidents as they have confidence in the investigation process and support this both locally and nationally (for example by using the National Reporting and Learning System). Integrated systems enable patient safety incidents (including those that were prevented and/or led to no harm), complaints and litigation cases to be analysed together. Staff, patients and relatives are actively involved and supported from the time of the incident through a being open process. The organisation has a high level of openness and trust.
04.	Investigating patient safety incidents	Incidents are superficially investigated by a junior manager with the aim of 'closing the book' and 'hiding any skeletons in the cupboard'. Information gathered from the investigation is stored but little action is taken apart from disciplinary action ('public executions') and attempts to manage the media.	Investigations are instigated with the aim of damage limitation for the organisation and apportioning individual blame. Investigations are cursory and focus on a specific event and the actions of an individual. Quick-fix solutions are proposed that deal with the specific incident but may not be instigated once the 'heat is off'.	Senior managers are involved in the investigation, which is narrow and focuses on the individuals and systems surrounding the incident. There is a detailed procedure for the investigation process, which involves the completion of multiple forms – the investigation is conducted for its own sake rather than examining root causes. There is a concern to review procedures or change the dissemination of procedures. Emphasis is placed on placating the patient/carer in a perfunctory way rather than informing, being open and supporting them.	Investigations, occur in order to gain an independent perspective. The staff involved in incidents, are involved in their investigation, which uses robust methods like root cause analysis and significant event audit to identify the contributory factors and system problems that led to the incident. The aim of investigations is to learn from incidents and disseminate the findings widely. Data from investigations are used to analyse trends, identify 'hot spots' and examine training implications. It is a forward-looking, open organisation. Patients are involved in the investigation process and their perceptions, experience and recommendations are sought.	The organisation conducts internal independent investigations using recognised techniques (e.g. root cause analysis and significant event audit), which include the staff and patients involved in incident. Investigations are seen as learning opportunities and focus upon improvement rather than judgment and include patient recommendations. The investigation process itself is systematically reviewed by all staff. Fewer serious incidents are occurring through learning from the past. It is a learning organisation as evidenced by a commitment to learn from incident investigations throughout all levels – from the Board through to healthcare teams and support staff.
05.	Organisational learning following a patient safety incident	It is not a learning organisation as no attempts are made to learn from incidents unless imposed by external bodies such as public enquiries. The aim of the organisation after an incident is to 'paper over the cracks' and protect itself – the organisation considers that it has been successful when the media do not become aware of incidents. No changes are instigated after an incident apart from those directed at the individuals concerned.	Little, if any, organisational learning occurs and what does take place relates to the amount of disruption that senior staff have experienced. All learning is specific to the particular incident. Any changes instigated in the aftermath of an incident are not sustainable as they are knee-jerk reactions to perceived individual errors and are devised and imposed by senior managers. Consequently, similar incidents tend to recur.	Some systems are in place to enable organisational learning to take place; this may include consideration of the patient perspective. The lessons learnt are not disseminated throughout the organisation. This learning results in some enforced local changes that relate directly to the specific incident. Committees and managers decide on the changes that need to be introduced and this lack of staff involvement leads to the changes not being integrated into working patterns.	The organisation has a learning culture and processes exist to share learning, such as reflective, sharing patient perceptions and significant event audit. Changes instigated address underlying causes (i.e. system factors). Staff are actively involved in deciding what changes are needed and there is a real commitment to change throughout the organisation. Hence changes are sustainable. The organisation 'scans the horizon' for learning opportunities and is keen to learn from others' experiences. Organisational learning following incidents is used in forward planning. It is an open, self-confident organisation. There is Board level support for in-depth incident investigations using root cause analysis and significant event audit.	The organisation learns from internal and external incidents and is committed to sharing this learning both within and outside the organisation. Patient safety incidents are discussed in open forums where all staff feel able to contribute. Incidents are seen as a learning opportunity – they are inevitable but learning can occur to reduce their likelihood of occurrence. Organisational learning itself is evaluated. Improvements in practice occur without the trigger of an incident, as the culture is one of continuous improvement. Patients play a key part in learning and contribute to subsequent change processes.
06.	Communication about safety issues	Communication in general is poor. What there is comes from the top down with no mechanism for staff to speak to their managers about risk. Events are kept in house and not talked about. The organisation is essentially closed. What communication there is, is negative, with a focus on blame. Patients are only given information which the organisation is legally bound to provide.	Communication upwards is possible but only after something has gone wrong. Communication is ad hoc and restricted to those involved in a specific incident. Communication is very directive, with the Board and senior managers issuing instructions. This is a 'telling-off' organisation. The patient is given the information the organisation feels is appropriate and it is a one-way communication.	There is a general communications strategy though it is not explicitly linked to the patient safety agenda within the organisation. Policies and procedures related to risk are in place, and lots of records about incidents are kept. There is formal communication between agencies and a large amount of written information is available. Patient comments are obtained and documented but not effectively utilised. This leads to an information overload meaning that little is actually done with the information recorded by staff and received by managers. A risk communication system is in place, but no-one checks whether it is working. Information provided to patients is driven by the fear of litigation.	The communications system and record keeping in general are both fully audited. There is communication across organisations facilitating meaningful benchmarking with respect to areas of potential risk. All levels of staff are involved from the Board down, and there are robust mechanisms for them to feedback to the organisation. Information about safety issues is shared; there are regular risk management briefing sessions where staff are encouraged to set the agenda. Effective communication regarding safety issues is made with patient and public involvement groups.	There is equality of communication about safety issues. The Board and more senior staff have an open door policy and realise that they can learn much from the staff that they manage. They expect everyone to know about and learn from each other's experiences, and it happens. It is a transparent organisation and includes patient participation in risk management policy development. Innovative ideas are encouraged. Electronic communication mechanisms are well-established and are the preferred mode within the organisation. This is a 'praising' organisation.
07.	Personnel management and safety issues	Staff are seen just as bodies to fill posts. There is no acknowledgement that personnel management is directly linked to any risk management agenda. There is a rudimentary HR policy, no structured staff development programme and no links with occupational health. Recruitment and selection processes are rudimentary. Staff feel unsupported and see Personnel as 'them' and not 'us'. Personnel take on a punitive role following an incident; the language used is negative and poor health and attendance records are seen as disciplinary matters.	Job descriptions and staffing levels change only in response to problems, so there are good selection and retention policies in areas where the organisation has been vulnerable in the past. There is a very basic HR policy, but it is inflexible and developed in response to risk management problems that have already been experienced.	Recruitment and retention procedures are in place though are distinct from risk management policies. There is a lot of paperwork and the policies are made available for everyone to look at. Credentials are always checked. The procedures for appraisal, incident investigation, staff development and occupational health are there, but are inflexibly applied, and so do not always achieve what they were designed for. These procedures are seen as a tool for the Board and/or senior managers to control staff.	There is some commitment to matching individuals to posts. There are also visible, flexible support systems tailored to the needs of the individual. There is review of personnel management processes in light of changes in risk management policy and changes are made when necessary. There are attempts to understand why poor safety performance occurs and to nip problems in the bud. There is genuine concern about staff health, and good systems of appraisal monitoring and review. Patient/carer input on safety and staffing issues is actively sought. There is demonstrable evidence of proactive measures taken in some areas (for example by using the NPSA's Incident Decision Tree following an incident).	The organisation is committed to its staff, and everyone has confidence in the personnel management procedures. Personnel management is not a separate entity but an integral part of the organisation. Reflection and review about safety issues occur continuously and automatically, rather than sporadically. There is a policy for employing patients and their representatives. Following a patient safety incident, a systems analysis is used (for example by using the NPSA's Incident Decision Tree) to make decisions about the relative contribution of systems factors and the individual healthcare professional. This process informs decisions about staff suspensions and as such there is a consistent and fair approach to dealing with staff issues following incidents.
08.	Staff education and training about safety issues	Training has a low priority. The only training offered is that required by government. It is seen by the Board and senior managers as irritating, time consuming and costly. There are consequently no checks made on the quality or relevance of any risk management training given. Staff are seen as already trained to do their job, so why would they need more training?	Training occurs where there have been specific problems and relates almost entirely to high-risk areas where obvious gaps are filled. Information about the risk management training available is given to new staff in an induction pack. It is the responsibility of the individual to read and act upon this. Education and training focus on maximising income and covering the organisation's back. There is no dedicated training budget.	The training program reflects organisational needs, so patient safety training is supported only if it benefits the organisation. No thought is given to actively involving patients in training. Basic Personal Development Plans are in place so everyone has their own file. However, these are not very effective as they are not properly resourced or given priority. Training about safety issues is seen as the way to prevent mistakes. There are a large number of courses on offer, however not all of these are relevant to the staff expected to make use of them.	There is an attempt to identify the risk management training needs of the organisation, and the training needs of individuals about safety issues, and to match them up. Such training is well planned and resourced and is available from and for all relevant agencies. Education is seen as integral to individual professional and personal development and is linked directly to other organisational systems, such as incident reporting. The Board and other senior managers understand and value risk management training for staff and encourage people to participate. Preliminary attempts to involve patients and the public in staff training are underway and the organisation is starting to learn lessons from its experiences.	The approach to training and education is flexible and seen as a way of supporting staff in fulfilling their potential. Individuals are motivated to negotiate their own training program. Education about safety issues is integral to the organisational culture. Learning is a daily occurrence and does not happen solely in a classroom environment. Patients are involved in staff training to aid understanding of patient perceptions of risk and safety.
09.	Team working around safety issues	Individuals mainly work in isolation but where there are teams, they are ineffective in terms of risk management. There are tensions between the team members and a rigid hierarchical structure. They are more like a group of people brought together with a nominal leader and no direction.	There are teams but they have been told to work together, and only pay lip service to team working. People only work as a team following a patient safety incident. Teams get put together to respond to external demands. There is a clear hierarchy in every team, corresponding to the hierarchy of the organisation as a whole. Teams do work together, but individuals are not actually committed to the team.	Teams are put together to respond to government policies (e.g. National Service Frameworks) but there is no way of measuring how effective they are. There is a risk management team. Teamwork is seen by lower grades of staff as paying lip service to the idea of empowerment. There is little sharing of ideas or information about safety issues across teams.	Team structure is fluid with people taking up the role most appropriate for them at the time. Teams are collaborative and adaptable and actively contribute to the risk management agenda within the organisation. There is evaluation of how effective the team is and changes are made when necessary. Teams may involve those external to the organisation.	Team membership is flexible, with different people making contributions when appropriate. Teams are about shared understanding and vision about safety issues rather than geographical proximity. This way of working is the accepted way in the organisation. Everyone is equally valued and feels free to contribute. 'Everybody is part of the risk management team', this includes all levels of the organisation from Board members through to those who have day-to-day contact with patients.