



# Setting the scene, headlines for 2022 from our work in maternity

**Dr Denise Chaffer RM**

Director of Safety and Learning, *NHS Resolution*



**@NHSResolution**



A serene sunset scene over a body of water. In the foreground, a small wooden boat with a blue hull is moored, its reflection visible in the calm water. Two long poles are propped up inside the boat. In the background, there are several fishing structures, including a small hut on stilts, and other boats scattered across the horizon. The sky is a mix of soft pinks, purples, and blues, with scattered clouds. The overall mood is peaceful and contemplative.

# Start with the end in mind.

Stephen R. Covey

# Starting with the end in mind

---

- Parents at centre of all care decisions
- Compassionate and consistent response to harm , with provision of evidence based interventions of support at time of incident for both families and staff
- Variation between units is significantly reduced/ eliminated
- Duplication of investigations and burden on providers eliminated
- Concerns managed at an early stage , single point of intervention and oversight but external bodies
- Evidence of learning - effective transition from recommendations to implementation leading to –
- Elimination of avoidable intrapartum brain injury

## Nursing and Midwifery annual registration report

---

### September 2021

21,800 nurses, midwives and nursing associates left register between July 2019 – June 2020 – (5.639 respondents) reasons given:

- COVID-19 pandemic (2.3%)
- Retirement (51.96%)
- Too much pressure, stressful, poor mental health (22 %)
- Negative workplace culture - bullying, poor management, difficulty raising concerns (18.1 %)
- Staffing levels (10.9 %)
- Disillusionment re quality of care to patients (11.1%)
- Leaving UK (17.8 %)
- Brexit (7.4 %)

# Where to start?

*'...the ambition for the NHS to be the largest learning organisation in the world.'*  
Jeremy Hunt, July 2015

- Create an environment that maximises learning
- Principles of a 'Learning organisation'
- Major in near misses and anticipatory factors
- Partnership with patients, carers and staff/utilising the experiences and views of families during the investigation
- Establishing a learning culture rather than a blame culture
- Supporting staff to be open

## Combining the common key components of learning organisations

<b>Building shared vision/aligning vision and values</b>	Argyris (1992)
<b>Leader installs organisational sense of commitment</b>	Argyris (1992)
<b>Commitment to wider larger system</b>	Argyris (1992)/Senge (1990)
<b>Staff commitment versus compliance</b>	Argyris (1992)
<b>Less hierarchical/Distributed leadership</b>	Senge (1990)
<b>Engage with staff/Empowerment of staff</b>	Argyris (1992)
<b>Identifies system factors and supports reliability of processes/Designs systems to prevent failures</b>	Senge (1990) Reason (1997)
<b>Builds capacity/Individual skills</b>	Argyris (1992)/Senge (1990)
<b>Promoting a culture of learning and development</b>	Senge (1990)
<b>Double loop learning / reframing</b>	Argyris (1992)



## Control versus open learning systems continuum

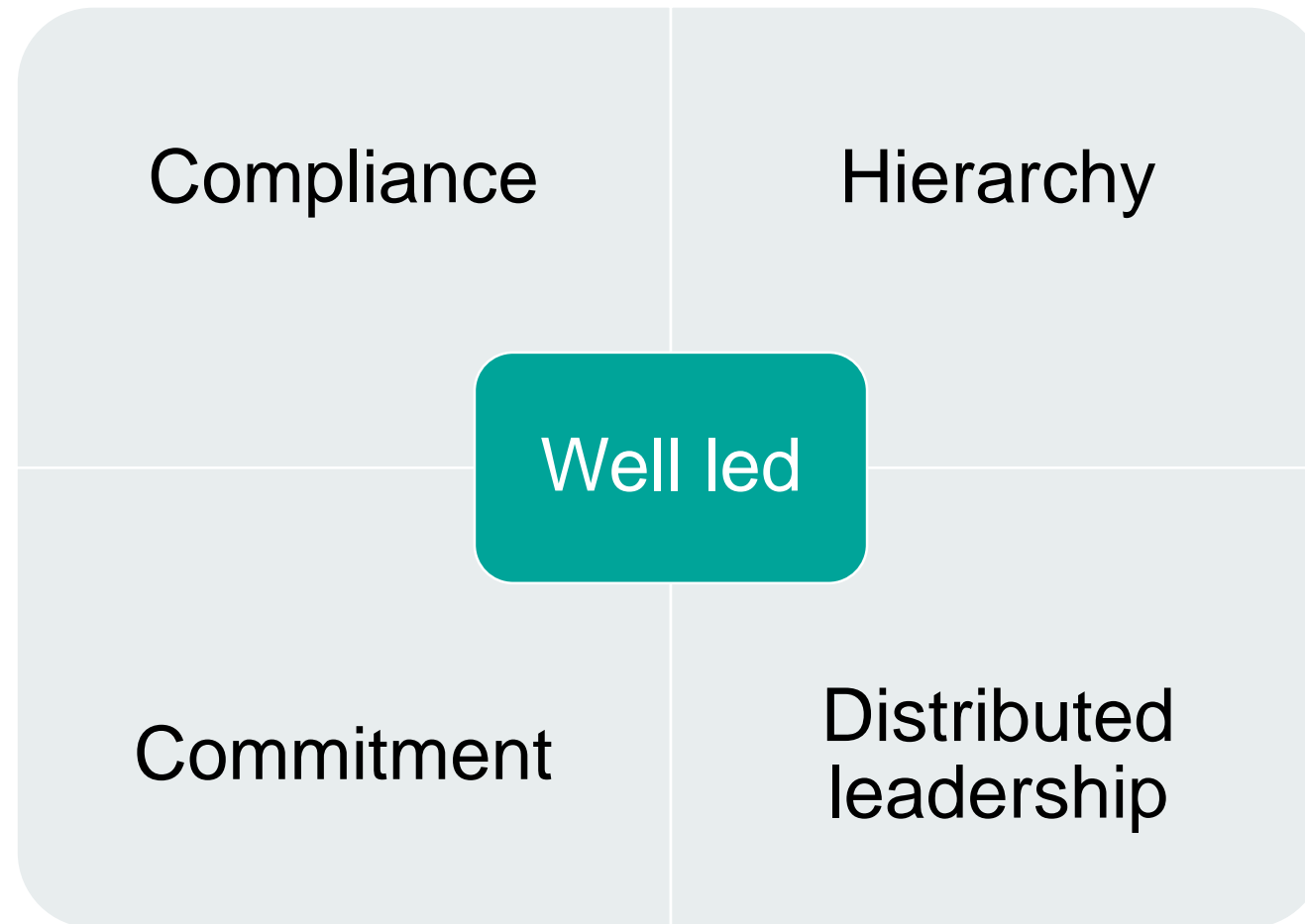
Traditional organisation	Learning organisations
Vision imposed on organisation	Shared vision & values
Managing and organising	Staff engagement
Control and compliance	Staff commitment
Hierarchy	Distributed leadership

# Hierarchy

Hierarchy	Lack of hierarchy
<b>Hierarchy with clear rules</b> <b>Clear chain of command</b>	Empowerment – distributed leadership
<b>Military style chain of command – efficient, goal orientated, competent</b> <b>Symbols of who is in charge</b>	Using relationships to get things done/ having a chat Easy access/Open door
<b>Clear accountability</b>	Chaotic/Informal processes



# Balancing polarities for being Well Led



# What do people expect?

## What do patients and families want?

- An apology
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Sign posting to support where appropriate

## What do staff want?

- Help to say sorry
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Sign posting to support where appropriate

# Response to harm

Support for patients, families, carers:

- Saying sorry guidance
- Duty of candour
- Mediation
- Support for Staff / Being Fair guidance / charter
- Joint guidance NHR/GIRFT
- Claims score cards



# Saying sorry

- Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them.
- Saying sorry is:
  - **always the right thing to do**
  - **not an admission of liability**
  - acknowledges something could have gone better
  - the first step to learning from what happened and preventing it recurring



# Saying sorry

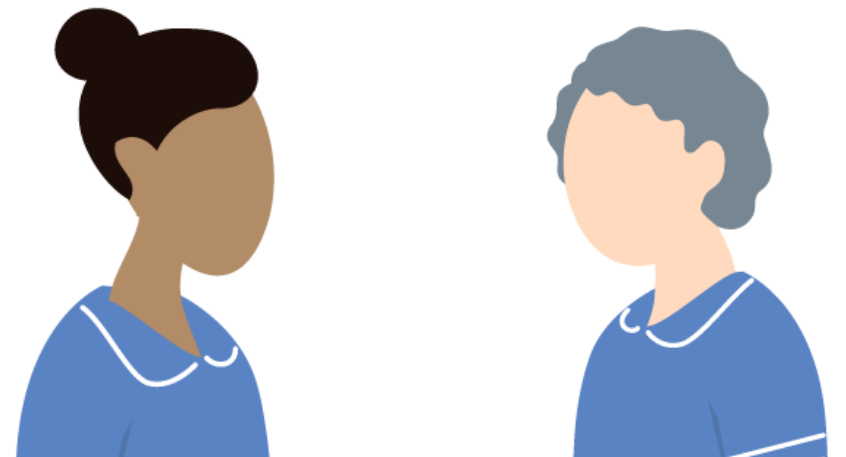
- Don't say
  - × I'm sorry you feel like that
  - × We're sorry if you're offended
  - × I'm sorry you took it that way
  - × We're sorry, but...

- Do say
  - ✓ I'm sorry X happened
  - ✓ We're truly sorry for the distress caused
  - ✓ I'm sorry, we have learned that...

# Saying sorry

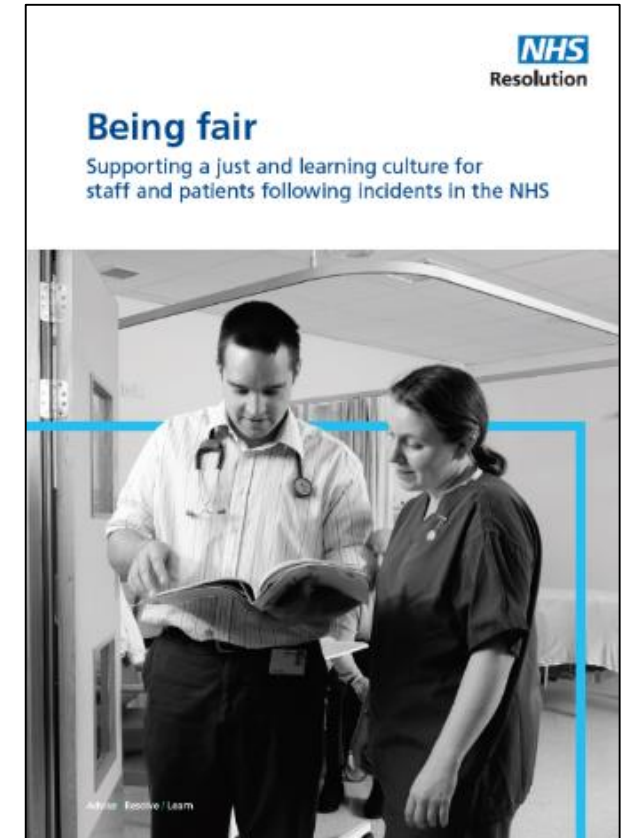
“We have never, and will never, refuse cover on a claim because an apology has been given.”

**Helen Vernon, Chief Executive, NHS Resolution**



# Being fair

- Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS
- *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.*
- All actions should be understood
- Staff should be supported to learn from their actions



Chaffer, D., Kline, R. and Woodward, S.



# Prevention of harm resources

---

Review of emergency care claims x 3

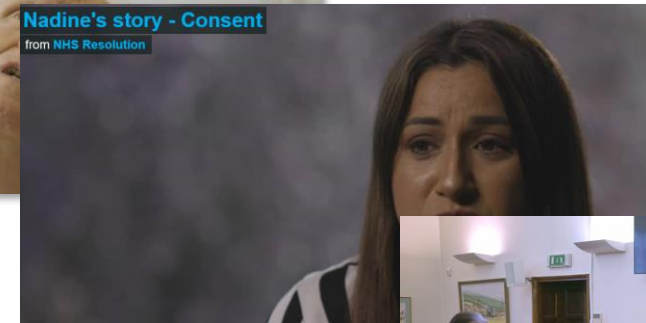
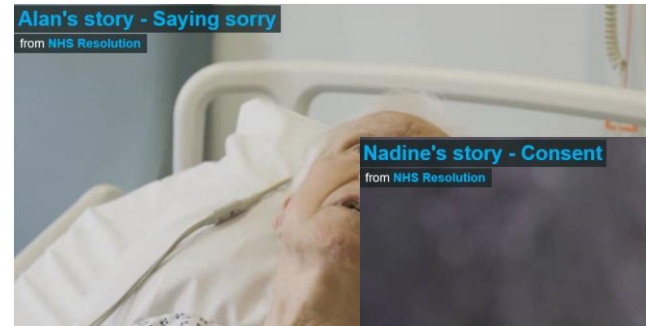
Diabetes and lower limb complications

To be published shortly:

- Review of first year GP / primary care claims
- Review of claims related to patients with diabetes with lower limb complications
- Review of EN cases – 2<sup>nd</sup> report of scheme
- Review of range of claims linked to nursing
- Review of ambulance providers claims
- Review of assaults on staff
- Review of claims related to learning disability
- Review Group B strep cases neonatal

Taking forward further work on fair and learning culture part 2 Being Fair

# Safety and Learning team



**Case story**  
Better joint working and specialist help  
benefits patients, families and the NHS

<https://resolution.nhs.uk/resources/>