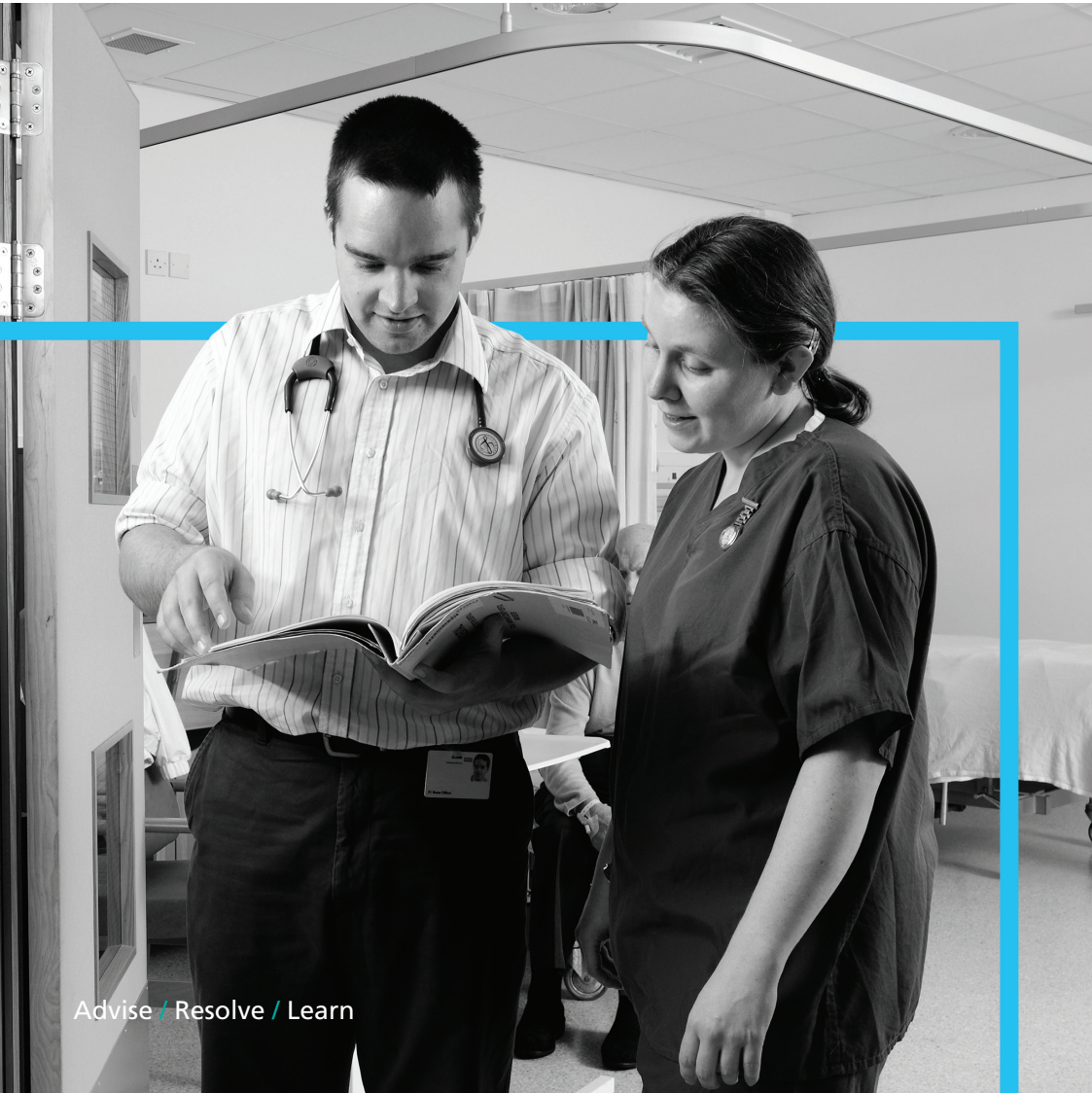


Did you know? Being fair

Supporting a just and learning culture for
staff and patients following incidents in the NHS



The vast majority of people who work in health and social care want to provide the very best care they can give. Sometimes things do not go as expected or planned.

There are associated financial and legal costs, but more importantly there are emotional, physical and psychological costs to patients, their families and to the staff involved. Focusing on improving patient safety and experience, and involving users of care services as well as staff in safety investigations is key.

In order to learn from these incidents to prevent the same things happening in the future there are three challenges that need to be addressed (Chaffer, Klein and Woodward 2018).

The three challenges that need to be addressed are:

1

Fear: There is a substantial fear of the consequences; fear of being blamed, fear for future employment and fear of what colleagues, families and friends will think which prevents people from sharing and learning.

2

Equity and fairness: There is significant variation between NHS trusts as to the likelihood of staff being disciplined or suspended. Research has shown that different individuals can also experience inequity, discrimination and suffer disproportionate disciplinary action, especially among black, Asian and minority ethnic (BAME) staff groups.

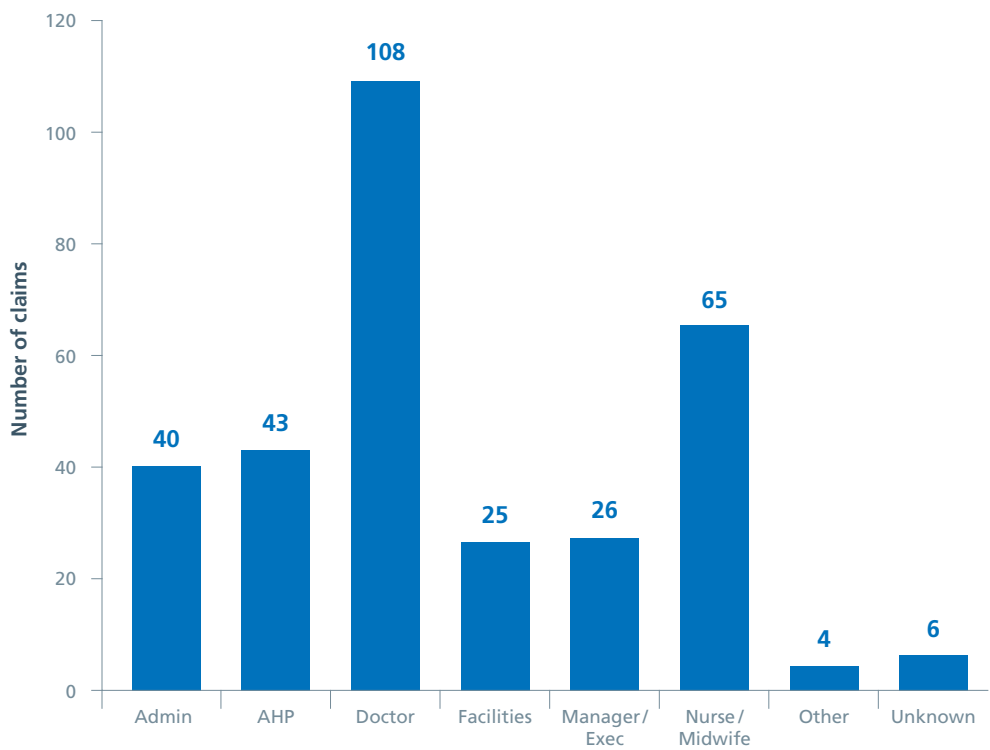
3

Stress and bullying: When things do not go as planned people experience stress, burnout, and subsequent loss of productivity. This is compounded by the current culture of incivility, bullying and harassment.

The last four years have seen **317 claims** notified to NHS Resolution worth **£27,479,003** in relation to staff stress and bullying.

These costs do not account for any associated payments for sickness absence or any replacement staff to cover duties or resources for investigation and management.

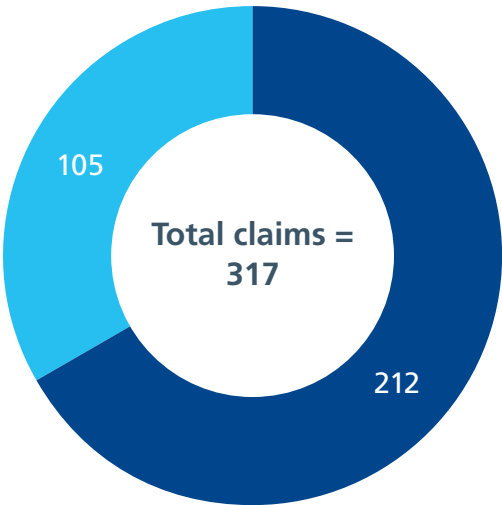
Staff affected by bullying or harassment



Between 1 April 2017 and 31 March 2018, a total of 7,087 cases were raised to *Freedom to Speak Up Guardians* in NHS trusts and foundation trusts. Some 45% of these cases included an element of bullying or harassment.

They also do not reflect the emotional impact and consequences to the staff member, the organisation in which they work and their patients, colleagues, friends and family.

Of these 317 claims (within the last 4 years), 212 were from women and 105 from men.



Organisations that staff work for

Foundation Trust	155	Community Trust	11
Acute Trust	131	Clinical Commissioning Group	6
Special Trust	14		

The majority of staff members making these claims were employed in NHS organisations, the majority being from Acute or Foundation Trusts which included 36 mental health organisations.

What needs to be done?

Build a restorative just learning culture

What we need is a restorative just learning culture (Dekker 2018) that is about repairing and building trust and relationships when things have not gone as planned.

Move away from fear and blame

- Urgently tackle incivility and the bullying culture and recognise the importance of role modelling and leading by example
- Address the health and wellbeing needs for staff to help them work safely
- Ensure staff engagement by building strong partnership with 'staff side' and the HR teams and develop staff diversity networks that help find alternatives to suspension and disciplinary investigation. Raise awareness about the disproportionate impact on certain groups of staff, notably BAME staff, and seek to redress this - where appropriate using third party advice (e.g. Practitioner Performance Advice service – part of NHS Resolution).

Balance equity and fairness, justice to ensure learning from incidents occurs and taking responsibility for actions that need to be taken

- Treat everyone fairly no matter what their background is and involve all particularly; patients, their families, staff and their colleagues
- Help everyone speak up and listen to them; staff, patients, relatives and the public
- Ensure the patient and family are informed in a timely way and apologies given.

Build a positive learning culture

- Involve patients and staff affected in any subsequent investigation and ask them for their ideas about what could be differently in the future
- Integrate current Safety I processes with a Safety II (Hollnagel 2013) approach to patient safety, i.e. learn about what has happened, what did not go as planned but also what worked well, how did the people and systems adapt or work to succeed and how can we replicate this.

Just and learning culture charter

The following is a suggested 'Just and Learning Culture Charter' for organisations to adapt and adopt.

Our organisation accepts the evidence that we will provide safer care and be a healthier place to work if we are a learning organisation. Humans are fallible; they make mistakes and errors.

- 1** Patients' physical and mental health must remain the paramount concern of any treating health professional, whether or not there is a dispute over treatment or a clinical error is alleged to have been made.
- 2** Clinical incidents have a real and deep impact on people's lives. Patients (or their partners or relatives) who have been affected have a right to explanations and to seek apologies, assurances and/or financial compensation for injuries caused where appropriate.
- 3** The vast majority of things that do not go as planned are due to unintentional acts and choices, and only a tiny minority are as a result of intentional acts, recklessness or wilful behaviours. Processes should be designed to support the vast majority of staff to help them work safely.
- 4** We need to take the blame out of failure. This means changing the mindset and the language associated with safety – from blame to learning. However, this does not mean an absence of accountability. Accountability is about sharing what happened, working out why it happened, and learning and being responsible for making changes for the future safety of staff and patients.

- 5 We will always want to understand why things don't go as planned in order to redesign systems and processes to minimise the chances of them happening again in future, and support individuals to work safely.
- 6 We will learn about what works well, and why, in order to replicate and optimise these behaviours and processes.
- 7 We will publish guidance summarising the fundamental principles of a just and learning culture which will be applied at all levels of our organisation, from the executive to the frontline.
- 8 We will recognise that people are less willing to speak up if they are afraid of being punished or prosecuted. We will build a culture where individuals feel able to speak up, offering different levels of access (e.g. freedom to speak up guardians) and ensure that when they do speak up they are fully supported within the organisation.
- 9 All people in contact with our organisation – employees, contractors, patients, relatives and the public – are encouraged, and sometimes even rewarded, for providing essential, safety-related information.
- 10 As part of our just and learning culture we will ensure that people are clear about where the line must be drawn between acceptable and unacceptable behaviour. As an organisation we recognise that incivility, rudeness and bullying are damaging both to staff wellbeing and patient safety, and we will seek to address these issues. That means being respectful, civil and kind.
- 11 We will ensure that all our staff recognise that inappropriate responses may disproportionately impact on some groups of staff, notably BAME staff.

- 12 People must be confident that their identity, or the identity of any person implicated in any report they make, will not be disclosed without their knowledge, unless this is required by law.
- 13 If a more formal investigation is required, we will ask what happened and why, and what can be learnt. A decision will be reached within a locally agreed reasonable timescale. When we investigate when things go wrong, we will try to recognise and minimise natural biases we all have, such as hindsight, outcome and confirmative bias. At all stages the emphasis will be on learning, not blame, and on why it happened rather than 'who did it'.
- 14 When a concern is raised or an investigation is required we will have in place clear governance to ensure that investigation reports are followed up, setting out which actions are being taken to address error-producing conditions in the future.
- 15 Those who report concerns will be notified in a timely way of the steps taken in response. Where patient care was compromised, the family will be told in a timely way in accordance with our duty of candour.
- 16 While we recognise that disciplinary action may be necessary, we will ensure suspension is rare and is never a knee jerk response to whatever has happened.

- 17 Our organisation recognises that there will be circumstances where referral to a professional regulator may be appropriate for some staff in certain circumstances within the thresholds set by the regulator. When that happens, it will only be done in accordance with our principles of learning and never as an additional punishment.
- 18 We recognise the importance of engagement with staff on this issue - linking patient safety to staff health and wellbeing, and recognising the contribution that frontline staff can bring. As an organisation we will emphasise the importance of staff wellbeing as a foundation for helping people to work safely. We will ensure that advice given by Occupational Health will be followed in a timely manner.
- 19 We will encourage and expect all staff to continually consider what factors can affect behaviour and performance, such as design of systems, processes, products, equipment and environmental factors. We will also consider factors including fatigue, workload, team relationships and communication on working safely.
- 20 We recognise the importance of role models and leading by example for senior leaders at executive level. Reports on progress in moving towards a just and learning culture will be a part of all leadership meetings, and shared with staff and patients appropriately.

Resources

Being fair: creating a just culture learning

Chaffer Klein Woodward 2019

Economic benefits of restorative practice

Kaur Dekker 2018

Restorative culture checklist

Dekker 2018

Bystander effect

<https://www.verywellmind.com/the-bystander-effect-2795899>

Safety I

Hollnagel 2013

Safety II

Hollnagel 2013

Acknowledgements

**Peter Walsh, AvMA, (contributions from AvMA
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