Supporting a ‘just and learning culture’

Ellen Nicholson
Safety and Learning Lead (General Practice)
NHS Resolution

Aims for today and what I am going to cover:

- What is a ‘just culture’
- Just culture toolkit and fair treatment charter
- Supporting staff
- Key principles and behaviour

- ‘just culture’ through the claims lens…
- Being Fair / Saying sorry
- Costs of incivility and benefits of kindness
- Safety behaviours

About NHS Resolution

Our purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care.

Strategic aims

Resolution
Resolve concerns and disputes fairly.

Intelligence
Provide analysis and expert knowledge to drive improvement.

Intervention
Deliver interventions that improve safety and save money.

Fit-for-purpose
Develop people, relationships and infrastructure.

NHS Resolution functions and strategic focus:

Strategic focus:

- Finding fair resolution
- Deploying insights as a catalyst for improvement
- Collaborating to improve maternity outcomes
- Transforming our business and investing in our people

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Resolving claims on behalf of the NHS in England and sharing learning from what we discover for safety improvement

- 11-12,000 claims for clinical negligence annually with compensation paid in just under half
- 75% settle without court and fewer than 0.5% go to trial

Critical that the response, from the start, is an open and honest one, for learning, to maintain trust and as the right thing to do.

A full and open conversation with an apology is more likely to prevent a claim than cause one.

Culture..?

Why do people claim?

NHS Resolution's research into behavioural insights August 2018

10,000 former claimants approached. 728 responded and in depth interviews undertaken with a sample

Key conclusions:

- NHS staff reactions generally considered inadequate
- Majority not satisfied with the NHS complaints handling process
- Suggestion from NHS staff major motivation to claim

What do families expect?

- 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

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

What do staff expect?

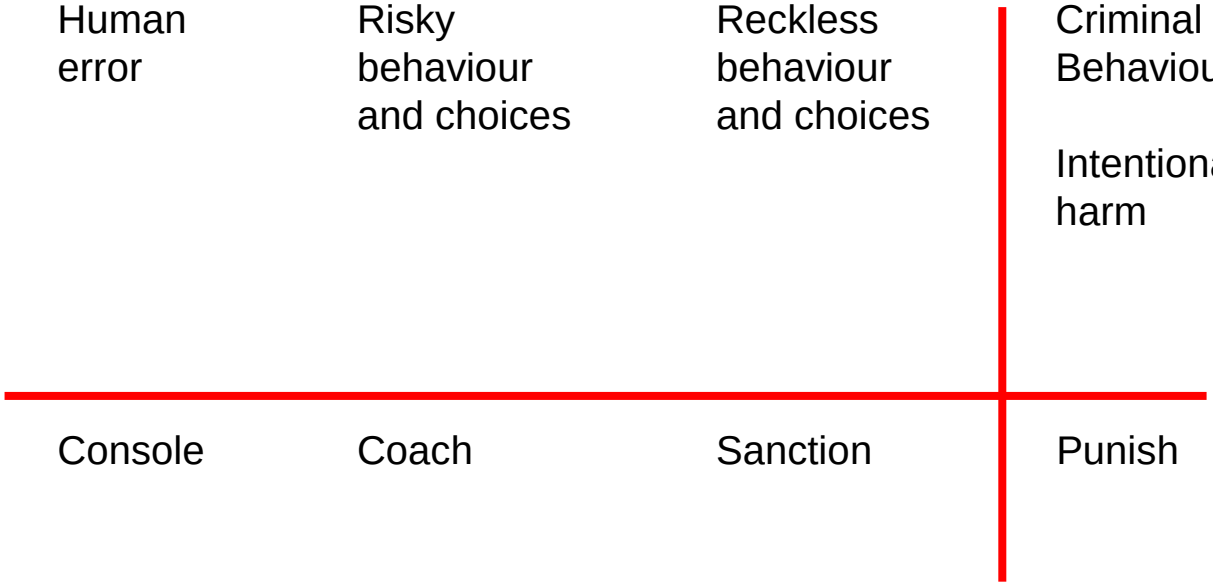
- Compassion, understanding and support
- An opportunity to give an apology
- Fairness and equity
- To learn and prevent it happening to someone else
- Sign posting to support where appropriate

Just Culture

Just Culture

Learning and accountability

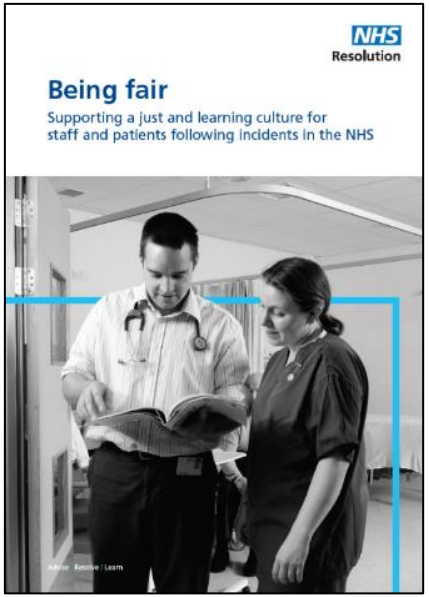
(Suzette Woodward 2017)



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.

A co-designed solution

NHS Resolution convened a roundtable (February 2018) of HR Directors, regulators, NHS arm's length bodies, plus some patient safety experts

The overarching aim of the group was to provide the NHS with the latest thinking together with guidance on how to replace blame with learning, and to ensure that there is equity for all staff and a proportionate response to concerns about performance or behaviour for all staff, regardless of race, ethnicity, disability or sexual orientation.

Three aims were agreed:

- To prioritise learning about how to minimise the conditions and behaviours that can underpin or lead to error rather than apportion individual blame
- Build a consistent approach for all staff, no matter what profession or what background
- A determination to avoid, wherever possible, inappropriate suspension, exclusion and disciplinary action unless there is wilful intent

Just and learning culture charter

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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.

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.

Impact on staff

A just and learning culture requires a balance of learning with accountability and assurance that staff and organisations take responsibility for making changes to help people work safely.

- Research has shown that different individuals can also experience inequity and discrimination, and suffer disproportionate levels of disciplinary action, in particular black, Asian and minority ethnic (BAME) staff groups
- Fear – of being blamed; future employment; personal reputation
- Mental health – depression, anxiety, suicidal ideation (plus physical health)
- Incivility and bullying – preventing ‘speaking up’ and reporting incidents

Description of harm in claims

1	Work-related stress – staff member was subjected to bullying and abusive behaviour by a consultant
2	Work-based stress resulting in suicide
3	Stress at work caused by workload and lack of resources
4	Staff member felt they were obliged to work excessive hours leading to suffering a stress-related illness
5	Following the death of a patient and subsequent investigation by the Trust, staff member felt isolated during suspension. This resulted in a significant psychiatric injury compelling them to seek early retirement
6	Depression, anxiety and work-related stress resulting from changes in role
7	Stress arising from failure to pay regard to complaint by staff member regarding staffing levels

Costs to employers

Incivility…

immediate loss of cognitive capacity.

staff cover costs, impacts on onlookers

reduction in the quality and time of people's work

knock on impact on patients safety. Decreased morale

Kindness

When people are recognised for what they do they are 23% more effective

When they are appreciated they are 43% more effective

Robbins M (2019) Why We Need Appreciation (Not Just Recognition) at Work via https://greatergood.berkeley.edu/video/item/why_we_need_appreciation_not_just_recognition_at_work

Costs to employers

- Staff cover costs (agency, locum, replacement costs)
- The likelihood of ‘presentism’ costs – where sick staff carry on working rather than taking time off to recover
- The cost of other staff affected by the suspended member of staff leaving (increased effort, increased workload, increased stress and decreased morale)
- The cost of management and other people’s time preparing for the case
- The considerable cost of legal advice
- Replacement costs if the staff member leaves
- Productivity costs

A restorative approach

Sidney Dekker (2018) – a restorative just culture:

- Support for staff, patients, families
- A focus on learning, not blame
- Support for staff – values and behaviours
- Reduce need for inappropriate disciplinary investigations (use of staff data)
- Early intervention by trained and committed senior staff
- Tools to aid reflection prior to any disciplinary action (where deemed appropriate)

Three powerful questions (Dekker 2017)

In order to achieve a restorative just and learning culture in the aftermath of when care has not gone as expected or planned, three questions should be asked:

- Who is hurt?
- What do they need?
- Whose obligation is it to meet that need?

Examples of some NHS practices

- **Example 1** - Just and learning culture charter
- **Example 2** - Restorative approach: Mersey Care NHS Trust and the use of a restorative approach adopted from and influenced by the work of Professor Sidney Dekker (2017)
- **Example 3** - Triage system: Barts Health NHS Trust and the use of a triage system to determine whether disciplinary action is necessary or inappropriate
- **Example 4** - A just culture guide: NHS Improvement 'just culture guide' which also acts as an aide memoire for people to assess the appropriate response when something goes wrong (NHS Improvement 2018)

Silence is not golden!

- https://www.youtube.com/watch?v=OLH8vTqO52c
- European science of works.

Your next steps – maximising environment for learning

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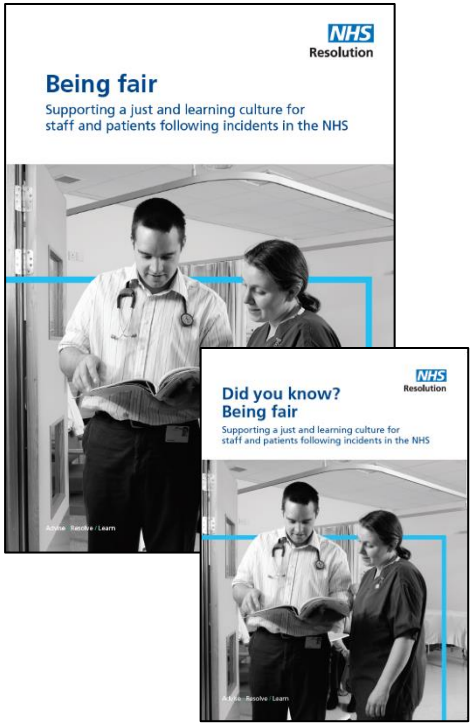
Discussion points:

- Why is this important for patients, families and carers
- Why is this important for staff
- What did you think are the key messages are from the guidance for you and your organisation
- What do you think are the opportunities and challenges
- What would support the implementation (signing up by organisations to the charter)

Conclusions

- A just and learning culture is for all: staff, patients and organisations. It is not only about safety; it is about how we treat each other, every day
- When things do not go as planned, patients' physical and mental health, and wellbeing will always be of paramount concern to healthcare staff
- At the heart of this are the rights of patients and their families to an apology, an explanation and to be involved in any subsequent reviews or investigations
- They also have the right to seek assurances and / or financial compensation where appropriate

Full report and leaflet available online



Thank you

Ellen.Nicholson@nhs.net
www.resolution.nhs.uk