

# Being fair

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





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# Key messages

**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.**

The vast majority of people who work in health and social care wish to provide the very best care they can, given the circumstances they are working in. There is very rarely intent by staff to provide care that did not go as expected or planned. While this guidance is predominantly about how staff are treated, this is with the intent to ensure that the benefits of a just and learning culture for staff will have a significant and positive impact on patients and their families.

All actions should be understood before being judged and staff should be supported to learn from their actions. Furthermore they should be asked for their advice and help to design the systems that could help change things for the better.

Those responsible for managing incidents should use the science of human factors, including investigative techniques, skills, expertise and methods that help us fully understand what happened in order to learn from errors or harm in the future.

We recommend using a balanced approach to safety, i.e. that we learn from when things go wrong and learn from when things go right. If we progress this thinking then the definition of safety shifts from 'avoiding something that goes wrong' to 'ensuring that everything goes right'. Then we can help people succeed under the varying conditions so that the number of intended and acceptable outcomes is as high as possible.

A resilient organisation helps staff work safely every day. Resilience also provides the ability for an organisation to sustain its operations under both expected and unexpected conditions.

In order to achieve a just and learning culture when care has not gone as expected or planned, three questions (Dekker 2017) should be asked:

- **who is hurt?**
- **what do they need?**
- **whose obligation is it to meet that need?**

A Just and Learning Culture Charter is provided (see example 1) for you to adapt and adopt which includes many of the key messages that organisations can consider.

# Co-designing the solution to developing a just and learning culture

A roundtable workshop of HR directors, regulators, NHS arm's length bodies and some patient safety experts was convened by NHS Resolution in February 2018 to explore the concept of developing a just and learning culture and to share best practice.

## Participants discussed the need for:

- Linking patient safety with staff engagement, health and wellbeing
- The balance of learning, accountability and responsibility
- An understanding of why or whether a disciplinary investigation is the right response following an incident
- Use of the science of human factors and the latest thinking on creating a just culture
- In addition, a focus on behavioural change and understanding more about a 'safety II' approach in terms of learning what works and the specific aspects of working in health and social care, i.e. the difference between how

work is actually done and not the work that people (leaders, policymakers, regulators) imagine is or could be happening

- Identifying what good practice looks like
- The importance of role modelling and leadership by example
- Creating ways in which staff can be listened to and using staff stories at Board level and other senior leadership meetings
- Building a strong partnership with 'staff side'/staff representatives and involvement of staff diversity networks
- Tackling incivility and the bullying culture within health and social care
- Where appropriate, using third-party advice (e.g. Practitioner Performance Advice service – within NHS Resolution).

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.

## Central to the approach in the future, the group agreed three aims:

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

What we need is a restorative just culture (Dekker 2018) that is about repairing and building trust and relationships when things have not gone as planned. This means we need to develop working practices that move people away from fear and blame, including tackling incivility and bullying, and addressing the health and wellbeing needs for staff to help them work safely. Ensure everyone's needs are met, no matter who they are. Treat everyone fairly, no matter what their background is, and help them speak up.

#### To create a just and learning culture the group considered a need for:

- All staff, patients and their families to be provided with appropriate support at all times
- To ensure that the culture is restorative for all and not retributive or adversarial (Dekker 2018 and 2017)
- A challenge in the current thinking and a change in mindset in relation to healthcare and how it could be safer, with a focus on learning rather than blame and with a focus on creating

the right conditions to help people work safely by truly understanding what work is like and not how it is imagined to be (Hollnagel 2013)

- An emphasis on ensuring that new staff (whatever their background, and especially if trained overseas) are supported and are aware of the organisation's values and the behaviours they should expect for themselves and from others
- An acknowledgement that excessive and inappropriate disciplinary action may be taking place in respect of staff from all backgrounds and especially, unwittingly or otherwise, those from BAME (black, Asian and minority ethnic) backgrounds
- Reduce the need for inappropriate disciplinary investigations
- Using staff data related to disciplinary action, suspensions and exclusions to check if any patterns of high (or disproportionate) levels of disciplinary action exist and why, and whether, over time, they are reducing
- Early intervention by trained and committed senior staff to distinguish between blame and accountability based on a thorough understanding of human factors, patient safety, the restorative just and learning culture, and behavioural psychology
- Speedy interventions to determine whether any form of disciplinary investigation is needed and timely resolution for all
- The use of a tool such as a triage approach, checklist or prompts simply to help reflection and challenge prior to any disciplinary action – and to use these with caution to ensure that they do not lead to an inappropriate focus on the individual or individuals, i.e. that they in themselves do not perpetuate a blame culture in some way
- Accountability of decision makers throughout the system to learn.



# Examples of practices used across the NHS

The following are just a few examples of what people are doing in the NHS as a way for others to see the kinds of ways in which a just and learning culture could be built.

Organisations are at different stages, and are still learning about what works. There are a variety of approaches being taken, with no single approach recommended over another (further examples of best practice may also be helpful to consider).

However the use of an agreed tool or framework by organisation is helpful in supporting a more consistent approach towards all staff groups.

**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).

# Example 1

## 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.



# Example 2

## Mersey Care - a restorative approach

**The approach adopted, and influenced by the work of Dekker, S. (2017), emphasises:**

- The importance of language
- The risk of hindsight bias
- Change of focus from policies that punish to policies that assist practice
- A focus on informal approaches over formal procedures
- A fair balance of justice, forward looking accountability and intervention - just culture
- Working with staff-side in partnership working
- Ensuring that staff feel it is safe to speak up, with specific mechanisms to support this
- The importance of sharing learning, anonymised if needed
- Refresh of the trust values and drawing on human factors science; introduction of new value of support, which includes encouragement to raise concerns so to learn from experience.

Analysis of the Trust's (disciplinary) cases has shown that the Trust has a high volume of disciplinary investigations, with over 50% of investigations resulting in there being no case to answer. Attention was therefore focused on the initial stages of the process and how the Trust determined that an investigation was required.

Mersey Care introduced template documentation which, they state, was probably one of the most significant factors in reducing cases. Whilst the documentation itself is simple, it encouraged those responsible for making the decision to ensure the appropriate information had been obtained and considered, before deciding to instigate formal proceedings, and the rationale was then clearly documented.

Where possible and appropriate, the Trust worked to make sure that those who may be subject to disciplinary investigation were able to contribute information to the process. The HR team advise managers with gathering appropriate information in the initial stages, but the focus is very much on investigating

and understanding the incident first, changing questions from 'who' to 'what' to get to a place of understanding.

There has since been a significant reduction in disciplinary cases. One of the four clinical divisions saw a 64% reduction in disciplinary cases between 2016 and 2017. Having a level of psychological safety, where issues can be raised and addressed before they escalate, is a major factor in improving both patient and staff safety.

In September 2018, the Trust completed a research study with Professor Dekker and Art at Work on identifying and evaluating the economic benefits of restorative practices. It was found that the introduction of restorative practices has coincided with many qualitative improvements for staff. The report highlights an estimated assumption of the economic benefit of restorative justice to be approximately 1% of the total costs and approximately 2% of the labour costs. These are estimates and are based on a relatively narrow window (a two-year period).

# Example 3

## Barts Health NHS Trust – pre-disciplinary checklist

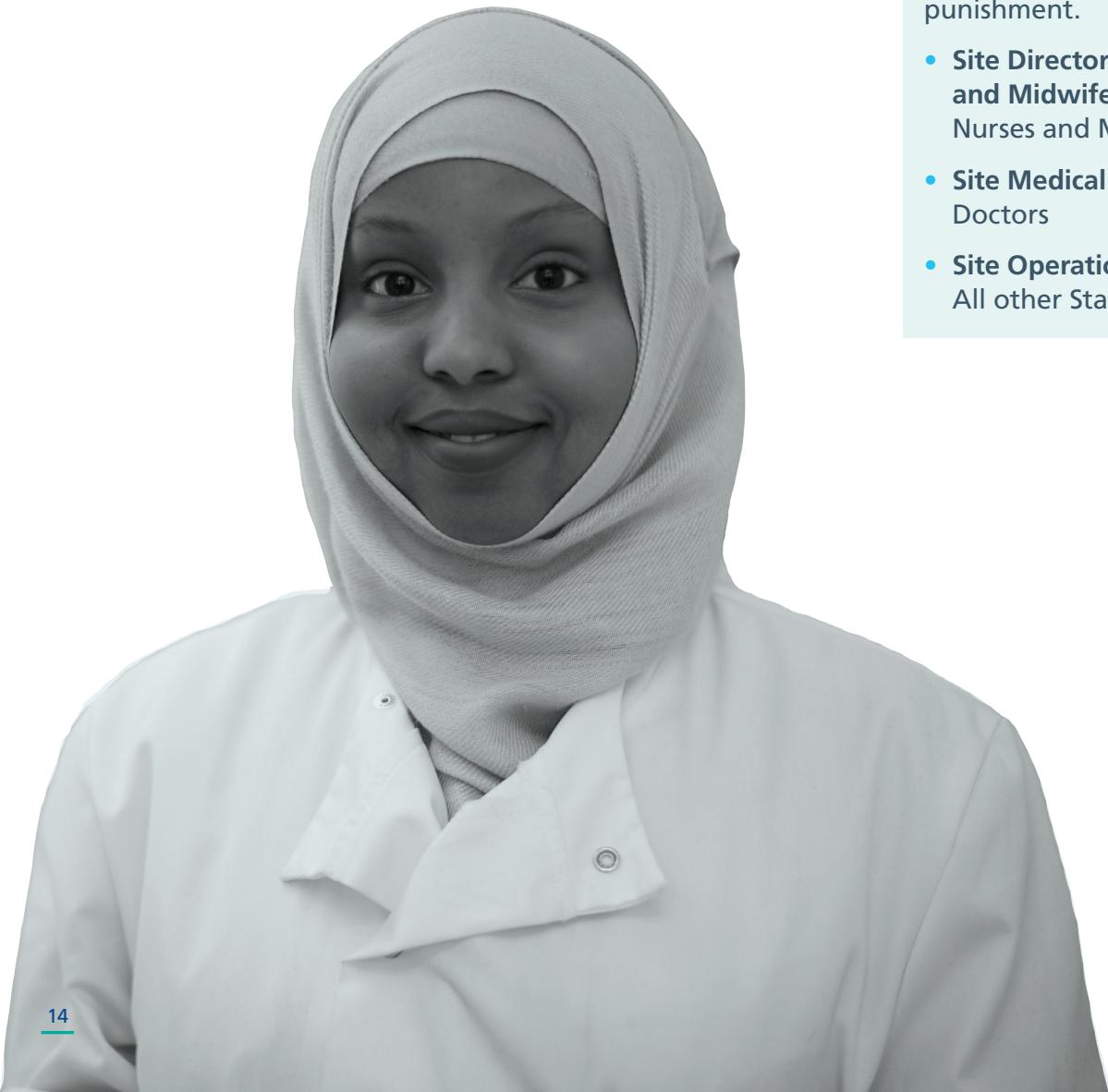
**At Barts Health NHS Trust, a pre-disciplinary checklist is used which has led in its first 12 months to a considerable reduction in the overall volume of disciplinary investigations and a significant narrowing of the likelihood of white and BAME staff entering the disciplinary process.**

A number of other Trusts have used similar approaches which stress the importance of having informal conversations at the very beginning, with a focus on learning rather than formal investigations which tend to focus on finding who is to blame. The precise format varies, but the principles are similar.

This checklist is to be used by the reviewing manager **BEFORE** a decision to formally investigate a worker is made.

The following triumvirate applies, where a decision is then made to establish that an investigation is appropriate and that all appropriate steps have been taken to cultivate a culture of learning from an incident rather than punishment.

- **Site Director of Nursing and Midwifery**  
Nurses and Midwives
- **Site Medical Director**  
Doctors
- **Site Operational Director**  
All other Staff Groups



## Have you asked yourself the following questions (1-6) before making a decision to formally investigate the individual concerned?

- 1 Is it a capability or conduct issue? (Y/N)**
- 2 If a conduct issue, does the conduct of the employee sit within the list of gross misconduct stated in the non-exhaustive list at the end of the Disciplinary Policy?\* (Y/N)**
  - a. Did the worker intend to cause harm? (Y/N)
  - b. Did the worker come to work drunk or was there any other noticeable impairment to their judgement or competence? (Y/N)
  - c. Did the employee knowingly and unreasonably increase risk by violating known safe operating procedures? (Y/N)
  - d. Would another similarly trained and skilled employee in the same situation act in a similar manner (the 'James Reason substitution test')<sup>1</sup> (Y/N)
- 3 Have you reviewed the worker's knowledge against their skills and determined if the worker knew of the rule or performance standard? If so, which of these applies?**
  - i. The worker does not have the knowledge of what to do and so can't in practice (Y/N)
  - ii. The worker knows in theory but can't in practice (Y/N)
  - iii. The worker knows how to and can in practice, but isn't (Y/N)
  - a. Have you done a preliminary investigation to understand the situation well? (Y/N)
  - b. Have you ensured you have taken statement(s) from the employee involved and given them an opportunity to present their version of events? (Y/N)
  - c. Have you exhausted the informal route? (Y/N)
  - d. Have you maintained consistency in dealing with this situation regardless of the employee's banding and protected characteristics? (Y/N)
- 4 How well have you reacted to this situation? Have you as a manager...**
  - a. Read the situation well (Y/N)
  - b. Got the employee's attention (Y/N)
  - c. Created the right relationship with the employee (Y/N)
  - d. Raised the concern informally with the member of staff in the same way you would with any other employee (Y/N)
  - e. Actively observed or identified which of 3i, ii, iii, 2c applies? (Y/N)

\* Questions 2a to 2d would be applicable in cases of Serious Incidents (SI)

<sup>1</sup> James Reason provides a decision tree for determining culpability for unsafe acts - Reason, J (1997).

**5 How open have you been in taking an overview of activities and impact**

- a. Have you ensured the employee understands the situation well? (Y/N)
- b. Have you ensured they have understood the rationale for applying the Disciplinary Policy? (Y/N)
- c. Do they understand the 'pause and review process' and the next steps involved in this? (Y/N)
- d. Have you checked if the employee is aware of various support mechanisms such as Trust Employee Assistance programme, OH, HR, and Union? (Y/N)
- e. Have we positioned praise or blame? (Y/N)
- f. Have we ensured they agree with the conclusion? (Y/N)
- g. Have the next steps been discussed with the employee? (Y/N)

**6 Given that our Trust's values and disciplinary policy emphasise improvement and learning, not punishment, have you:**

- i. Considered whether the employee has shown any remorse and understands the implications of their actions? (Y/N)
- ii. Have you considered 'plea bargaining' in the Disciplinary Policy?\*\* (Y/N)
- iii. Have you followed Trust values whilst dealing with this situation? (Y/N)

**7 Referring to question 3, if evidence is strong then:**

- If the employee does not know how, so can't in practice, then a development plan is required
- If the employee knows in theory, but can't in practice, then a development plan is required
- If the employee knows how to and can in practice, but isn't, then continue with formal investigation for disciplinary action.

**Finally, have you determined that, by carrying out an investigation for disciplinary action against this individual, it is consistent with how other employees have been treated for the same or similar misconduct/action? (Y/N)**

\*\* 'Plea bargaining' exists for where an offence arises and the individual admits to the offence; they can therefore accept the sanction (warning) without a long drawn out investigation and hearing. The manager must ensure the sanction is in line with the level of warning given in other related hearings to ensure consistency. It is a way of avoiding a formal process but not the sanction and can therefore only be considered for a first offence (because if it happens again then the individual hasn't learnt the lesson from the first incident).

# Example 4

## NHS Improvement – just culture guide

**NHS Improvement published a guide in 2018 to encourage managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.**  
**This guide updates and replaces the incident decision tree (IDT) developed by the National Patient Safety Agency (NPSA) around the work of James Reason, an expert in human error and its drivers.**

### NHS Improvement state:

- The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame
- Supporting staff to be open about mistakes allows valuable lessons to be learnt so that the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change
- This is our best current understanding on how to apply the principles of a just culture in practice, and that this is a live area of both academic and practical debate.

We will revisit and update this guide, as necessary, as our understanding develops.

**This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. The guide:**

- Asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counterproductive
- Helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are treated equally and fairly no matter what their staff group, profession or background. This has similarities with the approach being taken by a number of NHS trusts to reduce disproportionate disciplinary action against black, Asian and minority ethnic (BAME) staff.

The guide can be used at any stage of a patient safety investigation. It does not replace the need for a patient

safety investigation and it should not be used routinely. It should only be used when there is already some suspicion that a member of staff requires some management to work safely.

NOTE: A just culture guide will be reviewed later in 2019 in light of any recommendations from the Professor Sir Norman Williams Review.

### A just culture guide

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

**For further information:**  
<https://bit.ly/2R0hb4J>

### Scenarios to support training in using a just culture guide

To help with the training, we have developed a series of case scenarios that facilitators can use to walk people through the tool.

**For further information:**  
<https://bit.ly/2KakPYX>

# Background to guidance

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# Section 1

## Introduction and purpose

**This paper sets out the case for a just and learning culture for everyone working in and receiving care across health and social care.**

It provides the current context, considers the harmful impact on staff working in a blame culture, and assesses the latest thinking and evidence base for what good looks like. The theory and evidence around a just and learning culture are backed up by examples from organisations that have started on the journey to shifting the emphasis from blame to learning when care has not gone as expected or planned.

This paper is intended to start a conversation about what we could do differently across health and social care. It offers help for health and social care organisations who are considering the steps they could take in order to create a just and learning culture in their organisation no matter how big or small.

The paper applies as much to a small community team or general practice as it does to a large teaching hospital trust. While the conversation is predominantly about how staff are treated, this is with the intent to ensure that the benefits of a just and learning culture for staff will have a significant and positive impact on patients and their families.

This is about creating and supporting a just and learning culture for all in health and social care.

# Section 2

## Context and theory

**Over the last two decades there has been a concerted effort to make healthcare safer (Woodward 2017), but there is still much to do.**

The current data we have, together with a range of healthcare reports and inquiries over the years, have highlighted the need for improvements in how we learn about how to make care as safe as it could be (Kennedy 2001; Francis 2013; Berwick 2013; Kirkup 2015). This requires us to improve our learning about how day-to-day care is delivered, how it feels to work for frontline staff, and ways in which they need to adapt and adjust what they do to keep patients safe.

This means learning how care is delivered, not how we imagine it is delivered, but exactly how it is done on a day-to-day basis. It requires us to improve our learning about what is working well and what doesn't go as planned or expected (Hollnagel 2013). Underpinning this learning is a culture which is kind, respectful and which enables people to speak out openly, and to share issues, concerns and ideas without judgement (Dekker 2018).

A learning organisation is where everyone facilitates a culture that helps to continually transform and improve that organisation (Argyris, Putnam and Smith 1985; Senge 1990). A learning organisation that has safety at its heart studies all aspects of care. This, in turn, uses that knowledge to help people redesign the workplace; for example systems of work, the way equipment is placed and stored, the infrastructure and staffing needed, and processes of how care is delivered.

The mindset should always be to design systems that support the individuals within those systems to work safely. It also, importantly, includes learning about how people behave and what supports safer behaviours and decision making. This includes understanding the significant links between the health and wellbeing of staff and safer practice.

The latest thinking in safety is based on decades of research in human factors, sociology, psychology, cognitive systems engineering and other sciences. It reflects the development and balance of both restorative practices and accountability (Hollnagel 2013; Shorrock and Williams 2017; Woodward 2017; Dekker 2018).

If safety is both a state where as few things as possible go wrong and a state where as much as possible goes right (Hollnagel 2013), then organisations and leaders need to:

- be mindful of the potential for things not to go as planned; to understand the potential for risk and harm; and to take steps to prevent and minimise the impact
- seek to learn when things don't go as planned; learn so that things can be changed to the system and change things to help people work safely
- seek to learn from the day-to-day and from when we get it right in order to replicate this and optimise what we know we already do well.

There is a growing body of evidence that demonstrates that a way forward is to **embed a just and learning culture**. A checklist, or charter or framework provides the foundation for helping people create a just and learning culture; culture change cannot be achieved by these tools but they will help organisations to evolve, and grow in order for a just and learning culture to be embedded into every interaction people make.

Leaders, therefore, have the responsibility for role modelling the right behaviours to create and maintain a safe and supportive environment for both the patients and staff that is fair, open and able to learn. This includes employing and devolving decisions to embed safe practice among experts. This can be achieved by bringing together different professions, teams and departments to hear from everyone, no matter how disparate their views. It is vital that the changes needed to embed safe practice involve those who work at the 'sharp end' of the organisation and that those who receive care are truly listened to and asked how things should be done.

Ask the people who do the work every day and discover how the world looks from their point of view – both staff and patients (Dekker 2018). People should be seen as the solution to harness, not the problem to blame (Dekker 2018).

A just and learning culture also requires us to understand much more about the science and application of human factors. This should involve exploring the conditions in which people work in order to design the systems and processes to help work be as safe as it can be. It involves learning about why human beings behave as they do and what factors can affect their behaviour and performance, including design of systems, processes, products, equipment and environmental factors such as noise. It also includes an understanding of the impact of factors like fatigue, workload, team relationships and communication on working safely.

The study of human factors also helps us to understand how we should investigate when care has not gone as expected or planned in a way that seeks to minimise natural biases such as hindsight, outcome and confirmation bias (Shorrock and Williams 2017).

Turning to a just and learning culture, there are different views as to what this actually means. David Marx (2017) writes about identifying the different behaviours that are exhibited in the workplace. He describes how humans are erroneous, risky or reckless and he talks about how, by truly understanding these different behaviours, we can then respond appropriately and proportionately to these behaviours.

The term human error has been used for over three decades and is now accepted as a common explanation for 'when things go wrong' such as mistakes, slips, lapses and so on (Reason 1997). Some people also try to distinguish between each of these. There is a view that, by using the term 'human error,' it focuses the mind purely on the human being as the cause and not the circumstances that led to the error occurring.

### Marx (2017) suggests the following:

- 1 Human error** is inadvertent action or inadvertently doing other than what should have been done and it should be accepted that this is what we do as humans, that we are fallible and therefore people who are erroneous should be consoled and supported.
- 2 Risky or 'at-risk' behaviour** is when people make choices that could increase risk, or where risk is not recognised or where risk is believed to be justified. This includes what are often referred to as violations of policies or procedures and can also include forms of negligence. Marx writes that staff who exhibit risky behaviour should be asked about their

actions in a non-judgmental way first before seeking immediately to blame and sanction – there may be very justifiable reasons for these behaviours and these need to be understood and learnt from.

- 3 Reckless behaviour** is when people make choices that are considered reckless, i.e. putting people at an unjustifiable risk of harm. This could also include intentional acts, and a willful and conscious disregard to a substantial and unjustifiable risk. These people, Marx suggests, should be sanctioned in some way, but there also still needs to be learning from why people behaved in the way they did and the choices they made.

Dekker (2014; 2017) believes that it is more helpful to distinguish actions and choices as being either unintentional (the vast majority) or intentional (the very rare).

He and many others believe that the vast majority of people who work in health and social care wish to provide the very best care they can, given the circumstances they are working in, and that there is no intent to provide care that did not go as expected or planned. And that such incidents are unintentional and

there is no intent whatsoever to harm anyone. In all these cases, the actions and choices made should be understood before being judged and people should be supported to learn from them. Furthermore they should be asked for their advice and help to design the systems that could help change things for the better.

However, this does not mean an absence of accountability. The very rare person who does make an intentional act of harm should be dealt with responsibly and referred to

external bodies, including the relevant professional regulator(s) and the police.

The terms 'blame' and 'accountability' are often used interchangeably; this can lead to opportunities for learning to be missed. Brenner (2018) provides the following definition: '*Blame is to be accountable in a way deserving of censure, discipline, or other penalty ... accountable does not mean "blame-able".*'

Brenner (2018) also states that accountability means to be answerable and responsible for an activity, and the terms accountability and blame differ as follows:

#### **Learning versus punishment**

If blame is the goal, any investigation tends to stop after the 'culprit(s)' have been identified and the opportunity for learning is lost.

#### **Climate of fear**

Where staff express fear of accountability; this can be a strong indicator of a blame culture.

#### **Organisational chart altitude distribution**

Where accountability for actions is mainly focused at the bottom of an organisational structure; it is where blame is likely to be assigned.

#### **Acknowledging interdependence**

Recognising that all those accountable for an incident will commonly result in a long list, as incidents are usually linked to system failure and not individuals.

Dekker (2017) suggests that, 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?**

These are three very powerful questions that refer to everyone: the staff involved, the patients and their loved ones.





# Section 3

## Impact on staff

### Inequity

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. Threats to this kind of culture are apparent when staff are inappropriately blamed or face suspension following an incident, or are subjected to disciplinary action and sometimes dismissed. Too often people involved in complaints, incidents and claims are not supported, and instead they potentially face disciplinary processes which can lead to a culture of fear of speaking out.

In addition, 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. This can impact not only on the individuals involved, but on the teams they work within, and even the wider teams across the organisation and subsequently on the patients they care for.

In researching the causes of disproportionate disciplinary action in the NHS against BAME staff, Archibong and Darr (2010) found, in their report for NHS Employers, that:

*'...line managers found it difficult to deal with issues relating to disciplinaries and there were often inconsistencies in the application of disciplinary policies... It was perceived that managers were more likely to discipline B(A)ME staff over insignificant matters and that disciplinary concerns involving staff from minority ethnic backgrounds were not always considered to have been dealt with fairly and equitably by human resources managers.'*

ESR (Employee Staff Records) data show there is very significant variation between NHS Trusts regarding the likelihood of staff being disciplined or suspended.

- In 2016-17, NHS Trusts in England (98.7% n=232 of 235) reported that almost 16,000 staff entered the formal disciplinary process. 1.3% of white staff (n = 11,857) and 1.7% of BAME

staff (n = 3,854) did so (NHS Equality and Diversity Council 2017)

- According to the NHS ESR data, it is more likely that some staff will enter disciplinary investigations in some trusts compared to others. In addition, it is, on average, 1.24 times more likely (2017-18) that BAME staff will enter the disciplinary process (i.e. be subject to a formal investigation) than their white counterparts across trusts in England (NHS Equality and Diversity Council 2019)
- In 30 trusts (13%) more than 2% of white staff entered the disciplinary process and in 77 trusts more than 2% BAME staff did so
- This is an improvement on the previous year (2016-17) whereby it was on average 1.37 times more likely that BAME staff entered the disciplinary process
- In 70.1% of trusts, the likelihood of BAME staff entering the disciplinary process was more than for

white staff and in 59 (27.6%) trusts, the likelihood of BAME staff entering the disciplinary process was more than twice as high as for white staff (Equality and Diversity Council, 2019).

#### **There might be a number of reasons why this is the case, including:**

- All staff, including some BAME staff recruited recently from abroad, may not be adequately trained, managed or supported during and following their induction
- An excessive focus on blaming individuals rather than seeking to address the conditions, factors and possible system causes of the alleged performance or conduct issues, which might impact disproportionately on BAME staff. This may be because of “protective hesitancy”, whereby some managers find it difficult to have honest, informal discussions with some staff, notably with those from BAME backgrounds, which may increase the likelihood of those staff facing formal investigations rather than informal discussions (Archibong 2010)
- A variety of biases and attitudes by people (intentional or otherwise) influencing which individuals become subject to disciplinary investigations rather than deploying learning conversations where this would be more appropriate (Archibong and Darr 2010)
- Some jobs that BAME staff undertake may, irrespective of ethnicity, be those most likely to experience disciplinary actions being invoked.

#### **Fear**

When things have not gone as expected, there is a fear of being blamed, fear for future employment and fear of what colleagues, families and friends will think (Shorrock 2017).

Recent high profile cases have significantly heightened this fear, particularly among junior doctors. The fear is compounded by feelings of isolation, with the potential for significant impact on individual staff members (Kliff 2016). There are numerous cases cited of employees being suspended and prevented from contacting anyone as soon as an incident happens or a

complaint is made, irrespective of the potential outcome. This is now considered a key threat to a just and learning culture, as Lady Justice Hale pointed out in *Gogay v. Hertfordshire County Council* (2000):  
*‘...even where there is evidence supporting an investigation, that does not mean that suspension is automatically justified.’*

Involvement in incidents and complaints can also significantly impact on individuals' health and wellbeing. A UK study showed an association between staff involved in complaints procedures and risks of depression, anxiety and suicidal ideation (Bourne 2015). The association is likely to be impacted by the length of the disciplinary process. Professionals describe feelings of misery and insecurity, both during the process and in its aftermath. Another study reported that disciplinary action involving doctors can result in anger, guilt, shame and depression, and future ‘defensive practice’ (Cunningham 2011). In addition the emotional and psychological impacts of disciplinary proceedings and regulatory processes cause

immense stress on physical and mental wellbeing, including physical symptoms of short-duration migraines, skin rashes, irritable bowel syndrome, cardiovascular diseases and strokes (Bourne 2015).

### Incivility and bullying

A further threat to a just and learning culture is the way people behave towards each other on a day-to-day basis, in particular rudeness, incivility, lack of kindness and even bullying.

There is growing understanding of the issue and impact of incivility and rudeness in the workplace. Incivility is defined as 'the exchange of seemingly inconsequential and inconsiderate words and deeds that violate conventional norms of workplace conduct' (Porath and Pearson 2013). It may be the slightest thing, a sneer, a look of annoyance, being ignored in the corridor, being put down in a meeting or the use of belittling language. It can escalate to be much worse, such as humiliation in front of others and lead to bullying.

In healthcare this is adding to a culture of fear and is preventing people from speaking up. It also affects morale, and staff health and wellbeing. The impact on staff is considerable, and can affect cognition, and equally reduce safety, effectiveness, quality of work and productivity by the affected staff member(s) as well as those who observe this behaviour. Incivility is therefore harmful to both staff and to patients (Turner 2018).

Sadly, the scale and impact of bullying in healthcare is well documented. Almost a quarter of NHS staff report being bullied at some point in the previous twelve months. Bullying and harassment can impact in a number of ways. A climate of fear can lead to a lack of openness and willingness among staff to report errors or even share concerns through anxiety of the consequences. This inevitably leads to a less safe environment for patients. The impact on the workforce can be significant, leading to staff members experiencing high levels of stress, unhappiness and burnout and, ultimately, leaving the profession.

There is a recognised relationship between a positive workplace, learning from excellence, gratitude and appreciation, and improved patient care. It is vital that leaders and organisations work towards creating a positive culture that recognises and rewards success and kindness. What is needed is a culture where everyone, no matter where they are within the hierarchy, is respectful, kind, caring and civil towards one another.

# Section 4

## Claims

### Claims related to staff stress and bullying

The last five years have seen a number of claims notified to NHS Resolution (see Table 1) in relation to staff stress and bullying. The defined costs below do not account for any associated costs for sickness absence, any replacement staff costs to cover duties or resources for investigation and management.

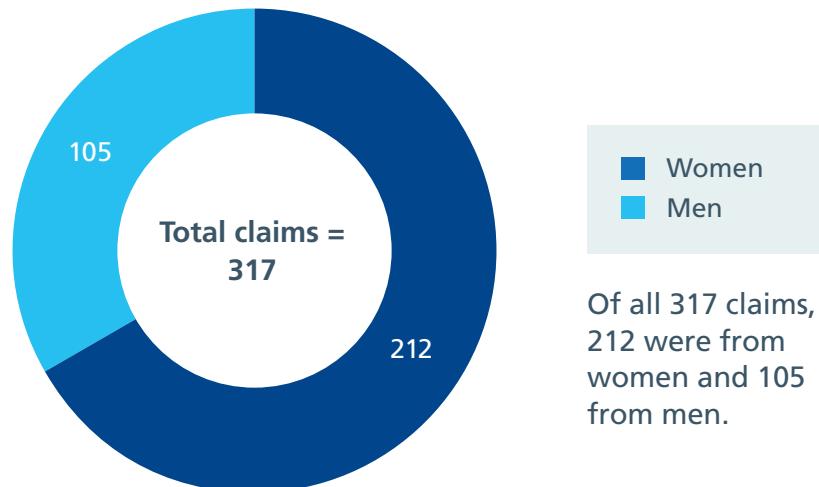
The cost alone does not illustrate the emotional impact and consequences to the staff member, the organisation in which they work, the patients that they may have to care for, and their colleagues and family members.

**Table 1: Numbers of all claims by date of notification and annual cost**

Notification Year	Number of Claims	Total Claims Value (£)
2013/14	67	3,096,707
2014/15	81	3,022,488
2015/16	68	6,624,735
2016/17	57	4,890,787
2017/18	44	9,844,286
<b>Grand Total</b>	<b>317</b>	<b>27,479,003</b>

- All claims notified to NHS Resolution. The figures represent the value of the claims registered. Some 91 cases are under investigation, in 92 cases damages were paid and in 134 cases damages were not paid
- There is commonly a time lag from the incident to the claim being notified as a claim to NHS Resolution and then resolved
- These 317 claims cover a range of incident dates, with over 50% of them being in the years 2013 to 2018.

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 (Table 2).



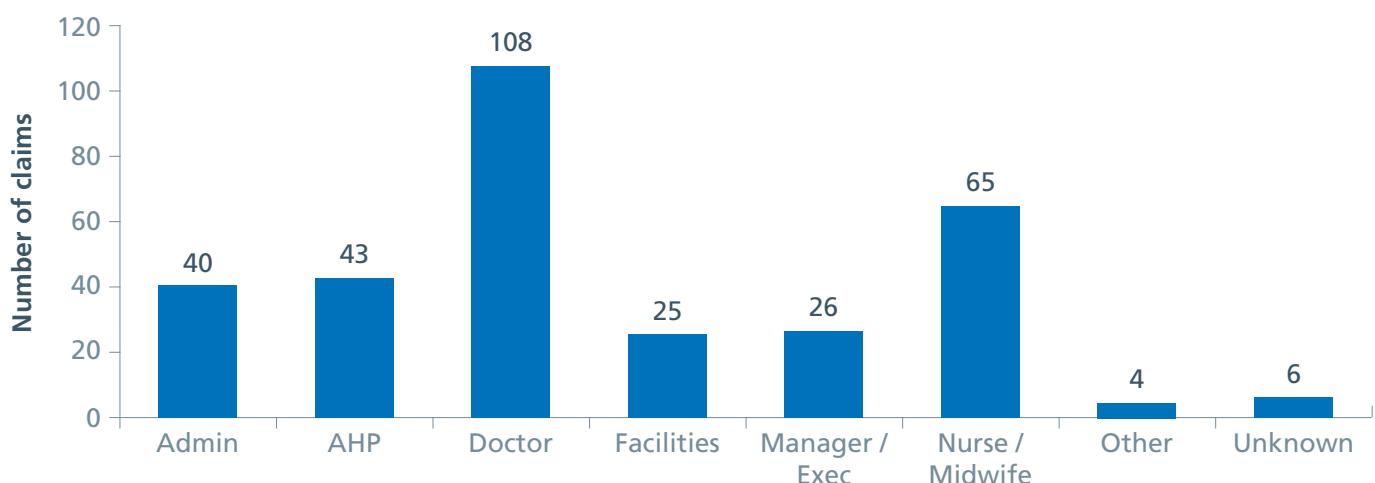
Of all 317 claims, 212 were from women and 105 from men.

**Table 2: Number and value of claims by type of NHS organisation**

Organisation Type	Number of Claims	Total Claims Value (£)
Foundation Trust	155	13,794,280
Acute Trust	131	10,885,969
Special Trust	14	1,490,617
Community Trust	11	997,070
Clinical Commissioning Group	6	311,068
<b>Grand Total</b>	<b>317</b>	<b>27,479,003</b>

The 317 incidents covered a whole range of staff, illustrating the extent of the issue and highlighting that it can affect staff at any level or role within an organisation (Figure 1).

**Figure 1: Claims notified to NHS Resolution 2013 to 2018 (n=317)**



**The numbers are significant and are driven by a range of avoidable factors in relation to how staff are supported. These include:**

- Failure to follow policies effectively relating to investigations and workplace stress
- Failure to follow advice given by Occupational Health and conduct a timely investigation, grievance or appeal

- Failure to provide a safe system of work and have regard for staff members' mental health and personal safety
- Failure to follow recommendations set out in the investigation report which caused the staff members' trust and confidence to be undermined
- Failure to carry out suitable or sufficient assessments of the risks to the staff members' mental health
- Failure to implement any adequate preventative or protective measures for the safety of staff members.

## Descriptions of harm within these claims include:

- |   |   |
|---|---|
| 1 | <b>Work-related stress – staff member was subjected to bullying and abusive behaviour by a consultant</b>   |
| 2 | <b>Work-based stress resulting in suicide</b>   |
| 3 | <b>Stress at work caused by workload and lack of resources</b>  |
| 4 | <b>Staff member felt they were obliged to work excessive hours leading to suffering a stress-related illness</b>  |
| 5 | <b>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</b> |
| 6 | <b>Depression, anxiety and work-related stress resulting from changes in role</b>   |
| 7 | <b>Stress arising from failure to pay regard to complaint by staff member regarding staffing levels</b>   |

# Section 5

## Suspension, exclusions and professional regulation

### Suspension / exclusion

The National Audit Office (NAO 2003) examined suspension in the NHS and the cost of disciplinary action taken in 2003. While this audit was over 15 years ago, the findings related to the impact of suspensions or exclusions are still relevant today.

The NAO found (in the year prior to publication, i.e. in 2002) that 1,000 clinical staff were suspended for, on average, 47 weeks for doctors and 19 weeks for other clinical staff. The cost estimated in terms of lost staff time, replacement staff, and administrative costs was in excess of £40 million per year.

Also in 2003, Hoel et al. examined the internal costs of one specific but typical local government employment relations case. The case involved the bullying of a graphic designer. It is argued that a disciplinary case is likely to have similar costs. Excluding lost productivity and the costs of any lump sum settlement, ill health early retirement, litigation or external legal advice or subsequent litigation, their calculation of the cost was £28,109 (or £44,125 in 2019 prices) (Hoel et al. 2003).

For the NHS, the amount of time and energy wasted

on poor, unnecessary or inappropriate disciplinary investigations, suspensions, hearings, appeals and legal costs is considerable. In 2012, almost a decade after the NAO published its report on suspensions, the Court of Appeal felt obliged to flag their own concern stating:

*'the almost automatic response of many employers to allegations of this kind to suspend the employees concerned, and to forbid them from contacting anyone, as soon as a complaint is made, and quite irrespective of the likelihood of the complaint being established... They will frequently feel belittled and demoralised by the total exclusion from work and the enforced removal from their work colleagues, many of whom will be friends. This can be psychologically very damaging. Even if they are subsequently cleared of the charges, the suspicions are likely to linger, not least I suspect because the suspension appears to add credence to them. It would be an interesting piece of social research to discover to what extent those conducting disciplinary hearings subconsciously start from the*

*assumption that the employee suspended in this way is guilty and look for evidence to confirm it'* (Crawford & Anor v Suffolk Mental Health Partnership NHS Trust 2012).

The Practitioner Performance Advice service at NHS Resolution (formerly known as the National Clinical Assessment Service, NCAS) can be contacted for advice where a healthcare organisation is considering excluding, suspending or restricting a practitioner's practice. Where patient safety is considered to be at risk or where there are allegations of serious misconduct, we work with healthcare organisations to help them consider the options available to them to understand and address the concerns, and to help ensure that their decisions are reasonable and proportionate to the circumstances. Where exclusion, suspension or restriction is thought to be appropriate we will continue to work with the healthcare organisation to routinely monitor the position and advise on good practice, taking account of local and national policy requirements.

## Professional regulation

Referrals to professional regulators may be a further measure taken as a result of what employers believe may be concerns about fitness to practice. These have been increasingly subject to public scrutiny with some regulators acknowledging the importance of a focus on learning, not blame and an increasing acknowledgement of the risks of discrimination (NMC 2018).

The cost of cases involving a referral to a professional regulator may be considerable. The NMC reported that '*through efficiencies to our processes in 2016–2017 the average cost of a hearing fell from £25,000 to £18,000*' (NMC 2017).

**However the costs to employers (and staff) include so much more than the cost to the professional regulator. They will include:**

- staff cover costs (agency, locum, replacement costs)
- the likelihood of 'presenteeism' 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.

# Conclusion

**The aim of this paper is to help leaders of all health and social care organisations to understand how they can support staff when things don't go as planned.**

**The paper provides the latest thinking, ideas and prompts which will, in turn, help to drive a just and learning culture within health and social care.**

It is also hoped that this paper will lead to an avoidance of inappropriate disciplinary action against staff, including in particular those from BAME backgrounds who appear to be disproportionately subject to such action.

The paper has highlighted why this is important and demonstrated some of the impacts on staff when support is not in place and the need to ensure consistent, equitable approaches across all staff groups regardless of the profession or setting. It has summarised some of the evidenced ways this can be done and shares examples where a few NHS organisations have implemented practices that emphasise learning rather than blame.

It is hoped that this paper will start the conversation which will lead to a significant change in mindset and attitudes to the prevailing practices in large parts of the NHS to benefit staff and patients.

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. This is embedded in the questions that Professor Dekker suggests: who was hurt, what do they need and whose obligation is it to meet the need?

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 financial compensation where appropriate.

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