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BLAME FREE CULTURE POLICY

INTRODUCTION

- This document sets out the basis of a blame-free culture (BFC) and the principles under which it will operate.

- To improve safety, it is important to move towards a culture less focused on blame and which "considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution". This has a positive impact on service user safety, creating an environment where individuals are supported in raising and resolving concerns, addressing incidents of unsafe care with empathy, respect, and rigour.

- On 30th July 2020, NHS England published the **NHS People Plan for 2020/21**. It describes itself as focusing on "how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care".

- With the Covid-19 pandemic having placed NHS workers under immense pressure in recent months, understandably much of this Plan places a strong emphasis on providing support for the physical and mental health of workers. This is welcome at a time where worker safety has become such a pressing concern, and it references important issues, such as effective infection control, providing appropriate personal protective equipment and the need for safe rest spaces.

- The blame culture is acknowledged as a key safety issue for the NHS in its Patient Safety Strategy, which states the need to "embed the principles of a safety culture within and across local system organisations".

- The purpose of a BFC is to generate an open and fair environment where errors and near misses are reported and examined, and where lessons are learned and established into new day-to-day practices, without the fear from workers that their mistakes will "count against them" in some way. This does not preclude formal reporting or actions in relation to incidents, however it does seek to establish the principle of openly reviewing routine errors, omissions, and incidents to learn from them without fear.

- The establishment of a BFC will not however override the need for proper professional or regulatory control or clinical accountability, which may be implemented over and above BFC procedures as the need may arise. All professionals will be made aware of the nature of the BFC culture and the limits under which this will operate in normal circumstances. It is expected that as part of their professional status they will be aware of the

professional and regulatory / contractual issues under which they must operate, and the nature of items which must be referred to regulatory bodies.

- Service user and worker safety hinges on the safe design, operation and maintenance of equipment, systems, and procedures, together with awareness of the human factors from which errors may arise.

POLICY

- Workers are encouraged to report incidents using the Significant Event Toolkit reporting procedure.

- Reported events will be documented by each person directly involved with the event and reported to the manager who will carry out an initial review.

- Where the manager considers that there may be regulatory or other significant reporting issues involved, he / she may terminate the normal review process (below) and seek advice from external sources or clinical stakeholders. At this point the matter will become confidential and controlled, subject to management discretion.

- Where the event reported is regarded as a "normal" event involving genuine error or learning issues, the matter will be discussed at an appropriate meeting of clinicians with the following key objectives:

    - Encourage any workers directly involved to present the item.
    - Encourage an open and honest discussion without a consideration of fault.
    - Identify the nature and cause of the incident.
    - Identify any actions required immediately to rectify the situation and to prevent a similar recurrence.
    - Discuss and document the nature of the incident, and how processes and procedures may be changed to improve safety or efficiency.
    - Discuss how and when changes may be implemented.
    - Agree implementation and a suitable review period to ensure that any changes have been firmly embedded within normal practice.