Being fair tool: Supporting staff following a patient safety incident

This tool should only be used when concerns about an individual's conduct or fitness to practise are raised during a patient safety learning response. It is not for routine use.

Patient safety incidents are usually signs of underlying systemic issues that require wider system-level action. Action singling out an individual is rarely appropriate.

By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

However, in rare circumstances a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances that the being fair decision-making tool can help you decide what next steps to take.

Where criminal activity is suspected to have contributed to death or serious life-changing harm, you should refer the healthcare incident to the police and be guided by the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies.

Before using the tool, consider the following questions (Sidney Dekker, 2022):

- Who is hurt? (for example, staff, patients, family, public)
- What do they need? (for example, wellbeing support, information on what happened)
- Whose responsibility is it to meet that need? (for example, occupational health,patient safety team)

Preconditions of use	
Do the concerns raised relate to a patient safety incident?	If **no** – **do not use this tool**. This tool is designed to help decide next steps in relation to patient safety incidents. Other processes should be followed for: • **safeguarding concerns** – follow your organisation's safeguarding policies • healthcare incidents where **criminal activity is suspected** to have contributed to death or serious life-changing harm – refer to the police and use the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies
Has a patient safety learning response that takes a systems-based approach been started or completed?	If **no – do not use this tool**. Healthcare is complex, characterised by multiple interactions between different human and technological factors. A systems-based approach looks at their interplay to understand the wider system issues, not the actions of individuals. **Only use this tool if a learning response begins to raise concerns about an individual's actions.**
Will the tool be used jointly by a member of the patient safety team and the workforce team?	If **no** – **do not use this tool**. This tool is designed to combine systems thinking and safety science expertise relevant to the patient safety incident alongside workforce expertise in supporting staff

Questions	**Action to take**
Q1 Substitution test – to ensure wider system issues have been fully considered	
1a. Does the learning response indicate that staff in the same peer group as the individual involved and with comparable experience and qualifications would have acted in the same way in similar circumstances?	**If yes**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If no or unsure, continue by asking the further substitution test questions

1b. Was the individual included when their peer group received relevant training? **1c Have you considered the experience and background of the individual (including differences in training practices between organisations or internationally and cultural differences)?** **1d. Was supervision in line with expected practice?**	**If no to any,** or the answer is unknown, discuss with the individual's supervisor or education lead. Continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q2 Foresight test – **to ensure wider system issues have been fully considered**

2a. Does the learning response identify any agreed protocols or accepted practices that apply to the individual's action or omission in question? **2b. Does the learning response find these protocols to be workable and reflective of accepted practice?**	If **no to any**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q3 Deliberate harm test

Q3. Based on what is known, is there any suggestion of recklessness, wilful neglect or an intention to cause harm?	**If yes,** follow organisational guidance for appropriate action, including contacting any relevant external organisations: for example, professional regulatory bodies, the police or, if statutory safeguarding processes need to be adhered to, the relevant lead – that is, person in position of trust (PIPOT) for adult abuse and local authority designated officer (LADO) for child abuse.

If no, continue to Q4 Health test

4a Based on what is known, is there any indication of substance use by the individual (for example, drugs or alcohol)? **4b. Based on what is known, is there any indication of physical or mental ill health that may have affected the individual's actions?**	**If yes to either,** follow organisational guidance for health issues affecting work.

If no to both, continue to Q5 Mitigating circumstances

Q5. Does the learning response or other information identify any significant mitigating circumstances for the individual's actions?	**If yes,** action directed at the individual may not be appropriate. Follow organisational guidance for appropriate action.

If no, follow organisational guidance for appropriate management. This could include remediation,supervision, additional training or disciplinary action.

If required, revisit the tool as further information from the learning response becomes available.

This is a continuous process with restorative just culture principles maintained throughout.