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# Managing risk and minimising mistakes in children's services

- Dr Lisa Bostock, Senior Research Analyst
- Paul Angeli, Service Manager, Southwark SSD
- Sue Bairstow, SCIE Associate
- Mathew Taylor, Voices from Care Cymru

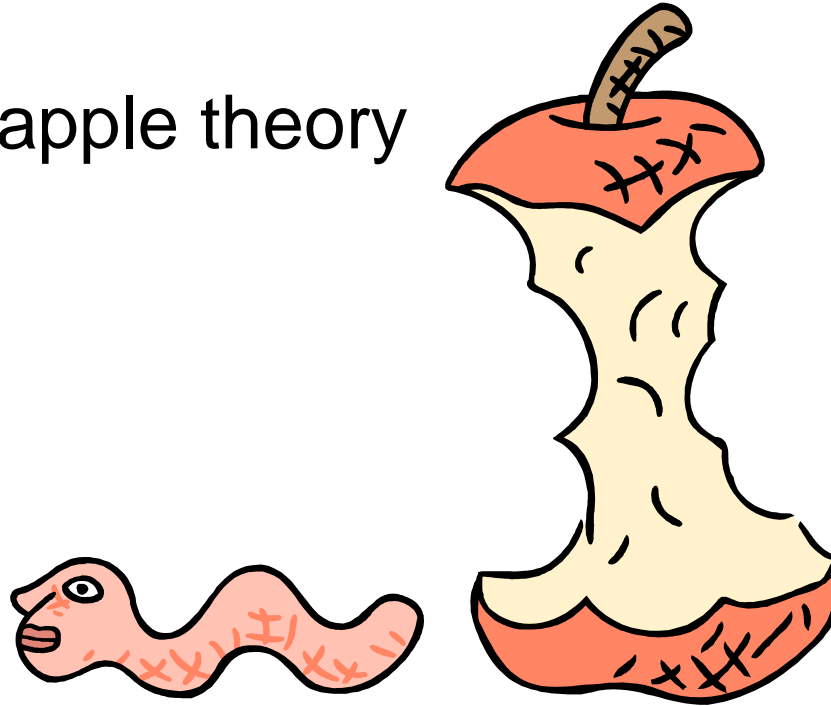
# Introduction

‘On this mistake management thing, there’s a culture of shame around mistakes and that needs to be addressed at its core. My teacher used to say “everyone makes mistakes that’s why they put rubbers on the end of pencils!” We need to encourage an open culture about mistakes so that we really can learn from them.’

Care leaver

# The old view of human error

- The bad apple theory



# Person centred approach

- Individuals who make errors are 'careless, at fault, reckless'.
- Blame and punish.
- Remove individual = improve safety.

# The new view of human error

- The bad barrel



# Systems approach

- Human error is a symptom of trouble deeper in the system.
- It is connected to features of people's tasks, tools and operating environment.
- Human error is not the conclusion of an investigation – it is the starting point.
- Change the system = improve safety.

# Ask why

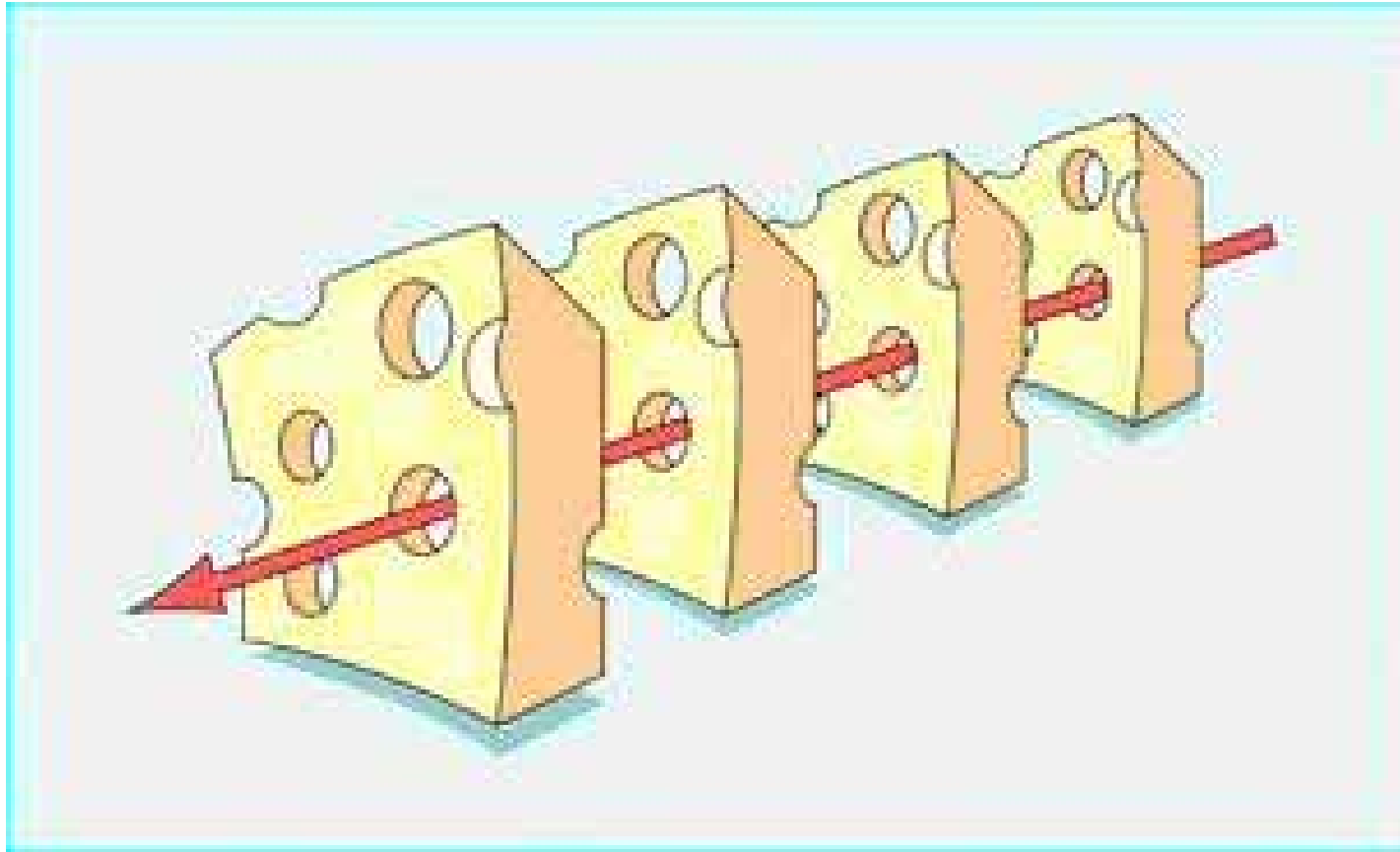
- Assume that people will make mistakes.
- Ask what makes it easier for people to make mistakes.
- Ask what helps keep children safe despite system failures!



# Why do things go wrong

- Barriers, controls and defenses
  - Latent failures – embedded in the system, associated with the actions of politicians, policy makers, senior managers etc.
  - Active failures - felt almost immediately and are associated with the actions of frontline workers i.e. errors of judgement and lapses in performance

# Swiss cheese model



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# Our study

- Qualitative research with three referral and assessment teams in England and Wales.
- Interviews with 60 social workers, their managers and allied professionals.
- Group and individual interviews with 40 young people and parents.

# What is a near miss?

Near misses involve the following features:

- something could have gone wrong but has been prevented
- something did go wrong but no serious harm was caused.

# Good practice, good learning points

- The ‘pew factor’:  
‘Phew that didn’t go wrong, but what about next time?’

Near misses contain both a sense of relief that nothing has gone wrong and also allow workers to feel good about themselves.

# Involving service users and carers

- Involve them in the analysis of incidents.
- Recognise the expertise of those directly affected by the incident.

‘I can’t undo my disaster now. It happened. I’m in it. But if we can stop the same thing happening to a few other people, then I’m happy to help.’

Parent

# Learning from adverse incidents

- Organisational learning triggered by serious harm.
- Lack of forums for analysis, recommendations and action arising from near misses.
- Cultures of blame, climates of fear and issues of leadership.

# Frameworks for learning

- Critical reflection
- Root cause analysis

For information including RCA training and toolkit or visit [www.npsa.nhs.org.uk](http://www.npsa.nhs.org.uk)



# Conclusions

- What is needed is a more comprehensive risk management programme that catches system failure before children are harmed.

# Case study – group exercise

- No harm, so no learning.
- Example of active failure at the frontline.
- BUT what are the contributory factors that led to it?

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