Learning From Incidents Workshop

A Better Care Together initiative
in collaboration with LIIPS

Update and next steps

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Task and finish group

“assess the policies and procedures for incident reporting across LLR and to identify mechanisms for sharing information and learning from incidents across LLR. The key emphasis for this group is sharing the learning across LLR organisations”

• Membership from across providers (UHL, LPT, Primary Care)
• Brought together patient safety and clinical staff
Task and finish group

• Four formal meetings (Nov 2015 – Mar 2016)
• Informal meetings and e-mail discussions
  • Reporting culture (in larger providers) seems quite robust
  • Investigations do not always get to the underlying safety systems issues
  • Learning and feedback within organisations is challenging
  • Learning and feedback across organisations does not happen

• Consistent with the national picture.
• Need to strengthen investigations (efficient, effective, independent eyes)
• Wider engagement across health community
  (to build inter-organisational links, provide a learning opportunity, shape culture and discuss systems)
Learning from Incidents workshop

• 85 enthusiastic delegates (clinicians and patient safety teams, including LPT, UHL, Primary Care, CCGs, EMAS, social services, care homes)

• Organised jointly with LIIPS, supported by EMPSC

• Keynote speakers
• Small-group case discussion
• Opportunities for networking
• Consensus building process
Consensus building process

Four questions:

a) ‘What does excellent look like?’
b) ‘What do we already do well?’
c) ‘What are the obstacles?’
d) ‘How can we get to excellent?’

Report sets out the results leading to a set of challenges and opportunities and recommendations.
### Recommendations

1. **Shared commitment and leadership**
   
   a) Enact a *just culture* and make a **joint commitment** to learn from patient safety incidents (commit to **patient-centredness**, **transparency**, **supporting staff** and working across organisational boundaries)

   b) **clear leadership** to drive learning from incidents **within** and across organisations
## Recommendations

2. **Supportive dialogue and collaboration between providers and commissioners**
   
a) Foster a **collaborative** and **mutually supportive** relationship.

b) Jointly explore how to **simplify** reporting for common, recurring scenarios.

c) Develop and pilot new approaches to investigation based on ‘**round table discussion**’ and agree when they would be a appropriate.
Recommendations

3. Development of a community of practice

a) Establish and foster a ‘community of practice’ for learning from incidents (across organisations; involving clinicians, patient-safety professionals and academics) to **share ideas, identify training/development opportunities** (and explore funding), **transfer knowledge** and champion **culture change**.
Recommendations

4. **Support investigations across organisational boundaries**

a) Support collaboration in investigating and sharing learning from *incidents which span organisational boundaries*:
   - protocol for *information sharing*
   - explore *‘joint investigations’* for complex incidents.
## Recommendations

### 5. Strengthening feedback and learning

a) Strengthen feedback and learning across the health system, adopting *evidence-based approaches* and good practice, *human factors* and *systems thinking*. Ensure that incident reports are a *catalyst to better systems and processes* at team, divisional, organisational, *commissioning* and *strategic* levels.
Recommendations

6. Triangulating incidents and other sources of patient safety data

   a) Strengthen existing mechanisms to systematically identify and share recurring themes and triangulate with other sources of patient safety data.
What can I do today?

Join our **Community of Practice** so that we can work together and support each other to improve our learning from incidents across organisations.
Community of practice

“Groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly.”

• Practical, ‘grass roots’ group
• Online, formal and informal meetings/events.
• Sharing knowledge, skills, resources and links
• Flexible

E-mail Rebecca.Perry@westleicestershireccg.nhs.uk for more information

Share this information with colleagues who might be interested and ask them to do the same!

This does not need to take up a lot of your time. Even if you are lacking in time or energy, please consider just signing up to receive our e-mail bulletin.
Conclusions and next steps

LLR should aspire to aim to remain a beacon of best practice, by fostering strong collaborative culture and systems.

Next steps

• Establishing community of practice.
• Action plan currently being developed to address recommendations.
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• All delegates who joined the incident workshop
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