
Our Listening and Learning (from events) Framework

# Quality, Safety and Experience Committee

December 2024

# Situation

- The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an update on the development of the Health Board's Listening and Learning (from events) Framework.
- The concept and areas for inclusion in the framework are currently being tested across the organisation through committees and groups.  Feedback received will be used within the final framework.
- The Listening and Learning (from events) Framework is integral to the Health Board's Quality Management System.

# Introduction

- For over 20 years, healthcare has talked about learning from events and whilst there has been some achievements in this area, there is still so much more work to do.
  - "To Err is Human" was published in 2000. The report was a spur for a rising interest in improving patient safety. The intention of the Institute of Medicine was to move away from finger pointing when things went wrong to focus on "how can we learn from our mistakes".
  - The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations (Putting Things Right) was enacted in April 2011 to review the existing processes for the raising, investigation of and **learning from concerns** and to ensure that learning from concerns lead to better quality and standard of care.
  - In 2015, "From Safety-I to Safety-II: A White Paper" was published. This white paper encourages health care providers to move from the approach of a focus on reducing error through ensuring as" few things as possible go wrong" to a focus on why things go right and **learning** from what goes well as well as when things do happen as planned.
  - The Health and Social Care (Quality & Engagement) (Wales) Act 2020 places a legal duty of candour on NHS providers in Wales. The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational **learning**.
  - The US Institute of Medicine first proposed the concept as systems in which "science, informatics, incentives, and culture are aligned for continuous improvement and innovation" in response to increasing complexity in healthcare and a need to improve the quality of care while reducing inefficiencies and costs.[1] Yet, a lack of practical guidance on how to enact such systems and a dearth of evidence indicating return on investment has led to justifiable scepticism about their achievability and prospective value.[2] In many improvement efforts, however, the **mechanisms for organisational learning are an afterthought**.[3]
- We have traditionally used safety notices, patient stories and improvement and learning actions plans as methods for sharing learning. However, anecdotal evidence would suggest that the learning has in many cases stopped on the ward, in the department or in the service where the event occurred. In some cases, there may have been learning across the directorate, but rarely has been organisational wide learning.
- There is increasing recognition that individuals do not all have the same learning style. Staff also have different access to information. If we are to ensure there is learning after an event, we need to listen to the needs of our workforce and ensure that we different methods of learning are used.
- Learning from events is an area where we will probably always have to stop, check what's happening, consider if the method right for the learning that comes from the event and right for our staff, and is there anything else we can do to share the learning.


"To Err is Human": A Report from the Institute of Medicine


From Safety-I to Safety-II: A White Paper


1. Smith M, Saunders R, Stuckhardt L, McGinnis JM. Best care at lower cost: the path to continuously learning health care in America.National Academies Press, 2013.
2. Hardie T, Horton T, Thornton-Lee N, Home J, Pereira P. Developing learning health systems in the UK: priorities for action.The Health Foundation, 2022doi:10.37829/HF-2022-I06
3. McDonald PL et al. Data to knowledge to improvement: creating the learning health system. BMJ 2024; 384 doi: https://doi.org/10.1136/bmj-2023-076175 (Published 25 January 2024)

# The importance of listening

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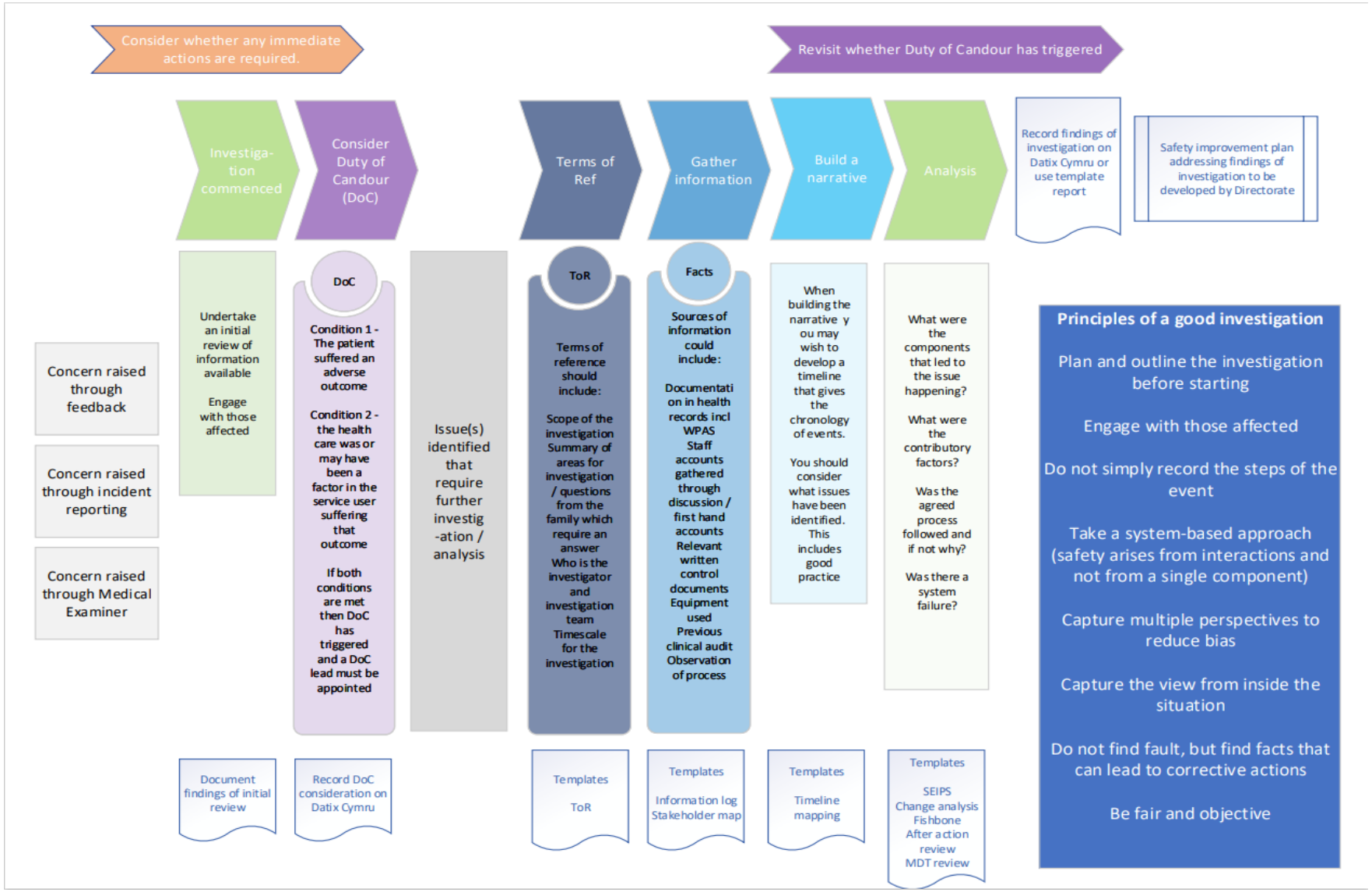
- Listening is a crucial element. In order to identify the events where we bring can gain the greatest learning, we need to listen.
- We need to listen to our staff. What are they raising through incident reporting, through speak up processes, through clinical audit and many other routes? What are our colleagues from outside of the organisation telling us, what is within our, and other organisations, Healthcare Inspectorate Wales reports, what is being highlighted through peer review, through Patient Safety Solutions, and through HSSIB report? And what are our patients and residents telling us through feedback mechanisms such as compliments and complaints? What are they telling us what has been there experience?
- We need to understand our data and what it's telling us, Our data and the information we hold can bring learning. Data can help us improve the care we provide. It can help us improve the quality of care will help us make our care safe, timely, effective efficient equitable and most important person centred

What events are included in the framework:

- Incidents
- Complaints
- Claims
- Redress
- Medical Examiner
- Inquests
- Safeguarding learning
- PSOW learning
- Patient / Staff experience
- Quality improvement projects
- Audit
- Spot checks
- Thematic reviews
- Peer reviews
- External inspections
- And more

# Our investigation process




Investigation is the right thing and required under PTR

but

what is point if we don't share the learning outside of our little silo's

# What is a listening and learning framework?

A learning health system is one “in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience” (Institute of Medicine, 2007).

The framework is our commitment as an organisation to ensuring we listen to our patients, learn from events, and create a positive safety culture where:

> “the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:
>
> 1) Continuous learning and improvement of safety risks
> 2) Supportive, psychologically safe teamwork
> 3) Enabling and empowering speaking up by all”[4]

4. NHS England » Safety culture

# What are our routes for learning?

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Examples of learning routes

- Investigation reports
  - Are these shared in departments, services, directorates, Listening and Learning Sub Committee?
  - But do we really shared across the organisation or do we stop in our silos?
- Improvement and learning action plans
  - Are these shared in departments, services, directorates, Listening and Learning Sub Committee
  - But do we really shared across the organisation or do we stop in our silos?
- Patient / staff stories
  - How are these cascaded wider than the committee where they are share?
- 7-minute briefings
  - Written usually by the Quality Assurance and Safety Team
  - How far are these cascaded?
- Internal safety alerts
  - Used rarely
  - How far are these cascaded?
- Learning from Events Reports
  - Are these shared in departments, services, directorates, Listening and Learning Sub Committee
  - But do we really shared across the organisation or do we stop in our silos?
- Individual Reflection
  - Do staff use their experience for revalidation?

Where can we share the learning face to face?

- Quality, Safety and Experience Committee
- Quality, Safety and Experience Sub-Committee
- Listening and Learning Sub-Committee
- Directorate quality and governance meetings
- Service team governance meetings
- Ward/department meetings
- Professional forums e.g. SNMT
- Grand Round
- Whole Hospital Audit
- Morbidity and Mortality Meetings
- Scrutiny panel
- Safety and assurance meetings

# What are our responsibilities for learning?

- Individual staff
  - Involvement in investigations
  - Reflection for personal development (from an event they witnessed or from learning shared)
- Department / ward managers
  - Sharing of the learning from department events – finding routes that all staff can access
  - Sharing of the learning from across the organisation
  - Encouraging individual reflection
  - Developing a culture that is a psychologically safe
  - Allowing time for SWARM huddles and After Action Reviews
- Service Management Teams
  - Sharing of the learning from events at quality and governance meetings
  - Sharing the learning from within the service with others in directorate
  - Sharing of the learning from across the organisation – cascade of information, inviting others to present
  - Developing a culture that is a psychologically safe
- Directorate Management Teams
  - Sharing of the learning from events at quality and governance meetings
  - Sharing the learning from within the directorate with other directorates
  - Sharing of the learning from across the organisation – cascade of information, inviting others to present
  - Developing a culture that is a psychologically safe
- Corporate Teams
  - Developing a central resource library for sharing of learning

Everyone has a responsibility to seek opportunities for learning.

This is as important as information being shared by others

# Using our Internet/SharePoint / Viva Engage …

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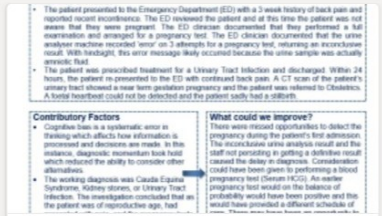
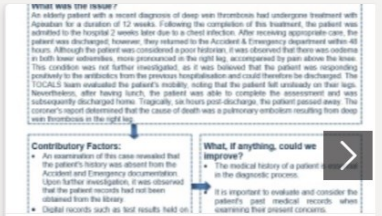
Links to articles etc relating to patient safety

7 minute briefing - DNACPR HIW National Review

Themes-Learning-Poster-Delayed-diagnosis-of-Spinal-Injury



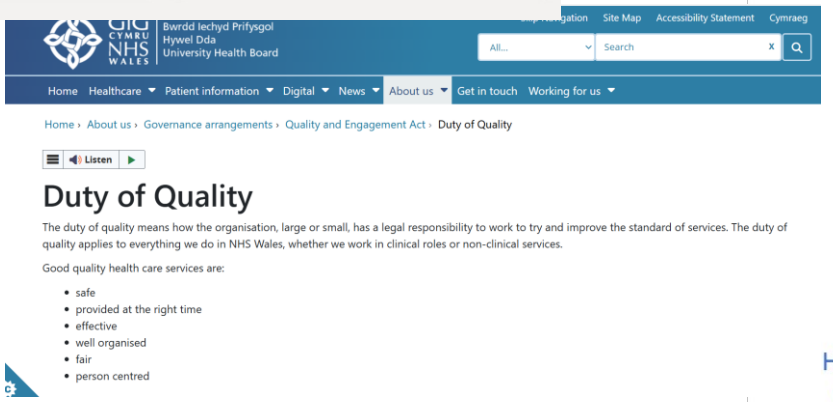
Themes---Learning-Poster-Delayed-diagnosis-of-pregnancy



Themes--Learning-Poster-Missed-diagnosis-of-a-pulmonary-embolism

The framework is just the starting point…

- Aim to have a learning library searchable by key word
- Need commitment from professional groups and directorates/services/teams to feed learning from events into the library
- Need to publish our quality improvement stories regularly to inform patients, stakeholders and others how we are meeting the duty of quality

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**Health and Social Care (Quality and Engagement) (Wales) Act Annual Report**

How we met the Duty of Quality and the Duty of Candour between April 2023 and March 2024

# Recommendation

- The Quality, Safety and Experience Committee (QSEC) is asked to receive this update on the development of the Health Board's Listening and Learning (from events) Framework.


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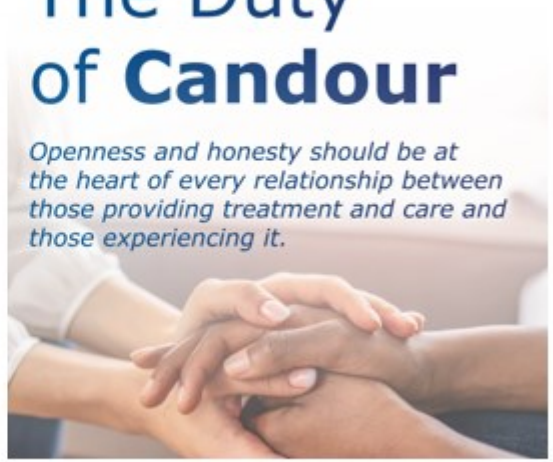


**DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG**

**SAFE | SUSTAINABLE | ACCESSIBLE | KIND**

# Appendix: Health and Care Quality Standards

- To help us understand what good quality means and how we can apply it in practice, the new Health and Care Quality Standards have been developed.
- There are 12 Health and Care Quality Standards. They are comprised of 6 domains of quality and 6 quality enablers.
- A high level definition of each of the 12 Health and Care Quality Standards is provided in the duty of quality statutory guidance.
- The Health and Care Quality Standards are intended to apply broadly to the wide range of services provided by the NHS in Wales.
- Services and specialties must be clear as to what good quality looks like in their individual areas by using the framework provided by the Health and Care Quality Standards.
- The Health and Care Standards help us to achieve our obligations in line with the duty of quality. They provide a quality-lens through which we can make decisions about the services we provide. The Standards help us to consider how we monitor and report on the quality of our services.


Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce


Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority


Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.


Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.


Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.


Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

## Quality enablers

**Leadership:** Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.

**Workforce:** Our healthcare system recruits, retains, develops and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future.

**Culture:** Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.

**Information:** Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.

**Learning, improvement and research:** Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.

**Whole-systems perspective:** Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.