2. Continually learn – December 2015

Overview

> *The most important single change in the NHS …would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.*
>
> – Don Berwick, A promise to learn– a commitment to act - 2013

Sign up to Safety is a movement for change, inspired by Don Berwick's seminal report. You are a crucial part of this community of people from across the whole NHS in England who are collectively creating the conditions for safer care for all patients, carers and staff.

Along with many others in the hundreds of organisations taking part, we know you are committed to believe in, embody and embed the values and beliefs that make us all proud to work in the NHS. These campaign values are found in our **five Sign up to Safety pledges.** These are much more than words on paper; they unite each of us signed up to the campaign. If we each bring these to life in our own organisations and help our colleagues to understand the role they can play, we will succeed in creating a positive safety culture, a just culture, and a learning culture.

This December we are looking more closely at our second pledge. We will host a variety of webinars, share opinion and learning from those at the frontline, and look at what it means to help create an NHS devoted to continual learning;

Continually learn

Review your incident reporting and investigation processes to make sure that you are **truly learning** from them and use these lessons to make your organisation more resilient to risks. **Listen, learn and act** on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are.

Why take an active part in this focus-month?

- It's an opportunity to remind everyone in your organisation of the Berwick report and its content and aims, especially around creating a learning culture
- It's a reason to talk to others in your organisation about the challenges related to learning from current methods of incident reporting and investigations
- Together, we can look at better alternatives for learning from incident reporting and investigations such as debriefs and huddles.
- It's a chance to explore different methods for learning from what goes right as well as wrong.

How you can get involved;

- **Bring *Continually Learn* to life**

Remind yourself and others of the aspirations of the report, A promise to learn - a commitment to act. You'll find key quotes at the end of this document. Use those in your staff and public communications so that others understand the value and ideal of a culture of continuous learning.

Look again at 'Old Myths and New Designs: The New Simple Rules for Health Systems', the keynote video from the IHI Quality Forum in April 2015, with Dr. Donald Berwick, *President Emeritus and Senior Fellow, Institute for Healthcare Improvement; Former Administrator, Centres for Medicare and Medicaid Service.*

- **SignPost the key resources, links and materials to others that we have curated to help you**

One of our most important jobs at Sign up to Safety is to use our time well, to save yours. We've curated some of the many existing resources out there that can help you and your colleagues learn more about this pledge;

  - Bringing learning to life; useful links (visit www.signuptosafety.nhs.uk/latest-thinking)

- **Take part in one of our webinars;**
  - 1 December, 10 am to 11 am; *'Continually Learning'*

    - **Rethinking incident reporting** and considering safety conversations to create a safety culture focused on continual learning

    Presented by **Suzette Woodward,** Campaign Director, Sign up to Safety
    Register
  - 15 December, 3pm to 4pm; *Involving patients and families in safety*

    - **Learning after an incident**: Inviting the patient and family to help create safer care and renewed trust. We're all in this together.
    - **Learning when care succeeds**: Hearing from patients and families what we do well, and why it makes such a difference.

    Presented by **Carolyn Canfield,** Independent Citizen Patient and 2014 Canada Patient Safety Champion by the Canadian Patient Safety Institute and Accreditation Canada
    Register

- **Look out for opinion pieces from different members of the campaign from across different care settings, which will be shared in SignUPdate across November and December;**
    - The third instalment in our series of opinion pieces from Jon Holley, CT2 doctor in Trauma & Orthopaedics & Director of SIPS (Staff Improving Patient Safety)
    - Our first opinion piece from Janice Perkins, Chair of Pharmacy Voice Patient Safety Group and Superintendent at Well, on how those who are competitors in a commercial sense work openly to share information with their rivals to ensure they advance knowledge across the sector and offer the safest possible service for patients.
    - Our regional lead for London (and former critical care nurse) Catherine Ede on own personal experiences of learning.
    - GP Dr. Hein Le Roux on what triggered his hunger to learn more about safety in primary care and how he keeps his enthusiasm alive
    - A short story by Adrian Plunket, Consultant Paediatric Intensivist, on the difference a positive safety investigation process can make
    - More on our emerging knowledge gained from our recent Beneath the Surface event, around using conversations to support a continually learning culture via suzettewoodward.org.

- **Share and discuss examples of different methods through which to learn;**
    - Boston's Brigham and Women's Hospital publicly posts case studies on patients who were injured when members of the hospital staff made medical errors. That means anyone can read about mistakes such as a five-month delay in diagnosing a cancer patient or an infusion in the wrong IV line. The hospital also explains the steps it's taking to prevent such errors in the future. It even quotes frustrated patients.
      Example of a case study

    - You are the Doctor video session from a Behavioural Exchange conference held earlier in 2015, which brought together leading academics, policy-makers and practitioners from around the world to discuss how behavioural insights can help us create better policy and a better society. This session shows a hospital through a doctor's eyes to help the audience look at better ways to set up health systems to help reduce avoidable adverse events.

- **Use our new practical guide on the benefits of using safety huddles or incident debriefs;**
    - Suzette will share her tips for facilitating multidisciplinary debriefs and huddles for learning from incidents

And remember;

- To help us all enhance our understanding of patient safety for the future, the team share their thoughts, experiences and insights on the common challenges we face, the priorities for Sign up to Safety, and what it really means to create a safety culture, a just culture, and a learning culture on our website here; www.signuptosafety.nhs.uk/latest-thinking
- Don't forget to look out for our e-newsletter SignUPdate & notices on twitter @signuptosafety. Subscribe to our newsletter and pass it on, keep an eye out on twitter – these are where we will share our learning across this month and beyond including our work on getting beneath the surface of why there is an implementation gap.

Sign up to Safety is fostering a movement across the NHS in England to make care safer. Be part of it.

www.signuptosafety.nhs.uk

Key messages from;
Don Berwick, A promise to learn – a commitment to act, 2013

Use these in your staff and public communications so that others understand the value and ideal of a culture of continuous learning.

- "Real, sustainable, active improvement depends far more on learning and growth than on rules and regulations"
- "And that is the balance we are suggesting that the NHS seek to strike – between the hard guardrails that keep things in proper order and the culture of continual learning that helps everyone to grow."
- "The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning"
- "The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS"
- "The NHS in England can become the safest health care system in the world. That will require unified will, optimism, investment, and change. Everyone can and should help. And, it will require a culture firmly rooted in continual improvement"

- "Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning"
- "Goals and incentives should be clear, fully aligned, and focused on the interests of patients, with a high level of coherence across the system as a whole. The best way to reduce harm is for the NHS to embrace wholeheartedly a culture of learning."
- "Resource constraints will undoubtedly continue in the NHS. There are two ways to deal with this reality. One is by simply cutting budgets and thereby placing the burden on staff of caring with fewer resources. The other, better, way is through improvement – introducing new models of care and new partnerships among clinicians, patients and carers that can produce better care at lower cost. Only a culture of learning and improvement can follow that better way."
- "All NHS leaders and managers should actively address poor teamwork and poor practices of individuals, using approaches founded on learning, support, listening and continual improvement, as well as effective appraisals, retraining and, where appropriate, revalidation."
- "Lead by example, through commitment, encouragement, compassion and a learning approach"
- "Commit to learning about patient safety as a core professional responsibility and develop your own ability to detect problems."
- "The entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate care and teamwork."
- "The most powerful foundation for advancing patient safety in the NHS lies much more in its potential to be a learning organisation, than in the top down mechanistic imposition of rules, incentives and regulations. Collaborative learning through safety and quality improvement networks can be extremely effective and should be encouraged across the NHS. The best networks are those that are owned by their members, who determine priorities for their own learning."
- "Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line."

- "Invest even more than ever before in learning, growth, development, ambition, and pride. This is the route that can make the NHS a "learning organization" in every sense of the term, and it can unleash momentum for improvement that no simple, top-down, control-oriented, requirement-driven culture ever can."
- "We are recommending four main principles to guide everyone in trying to build an even better "learning NHS." Here they are:
    - Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
    - Engage, empower, and hear patients and carers throughout the entire system, and at all times
    - Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
    - Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge."