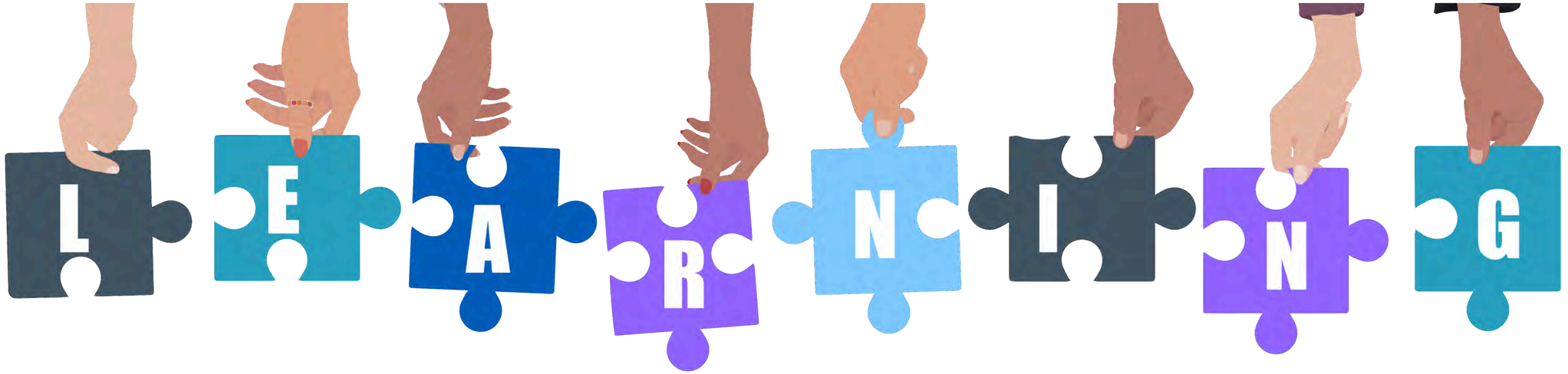
EPUT
Lessons Team
Be the driving force for true learning

NHS
Essex Partnership University
NHS Foundation Trust



LESSONS HANDBOOK

WHAT WE DO TOGETHER MATTERS

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FOREWORD

(See pgs.01-06)

Delivering high quality and safe care remains our top priority as a Trust. Identifying lessons that can be learnt from the experiences we have, either positive or otherwise, is extremely important in our goal of becoming the 'leading health and wellbeing service in the provision of mental health and community care'. Embedding learning into our practice, helps us in preventing unwanted reoccurrences of adverse incidents and in continuing to improve the services we provide.

We are committed to learning from our complaints, incidents, staff and patient feedback and will also take learning from the outcomes of national incident enquiries. We will learn from the best of what happens nationally and globally, whether from exemplar healthcare providers or other innovative and high-risk sectors. We will use this learning to continuously review our actions and improve our outcomes. To ensure delivery, we are working towards embedding continuous improvement within our culture of learning in the Trust.

We hope this procedural document demonstrates our commitment to place the safety of our staff and our patients as our top priority in line with our values of We Care, We Learn, We Empower.

Paul Scott
CHIEF EXECUTIVE OFFICER (CEO)

FOREWORD

(See pgs.01-06)

PATIENT SAFETY PARTNERS

"The curious paradox is that when I accept myself, just as I am, then I can change."- Carl Rogers

After twenty years of struggling with mental health that led me to alcohol and substance misuse, I realised the call from inside our hearts is what can make a difference.
I found EPUT during the first lockdown. Today enjoying EPUT services and the project it offers, including supporting the organisation as a Patient Safety Partner and being part of such a co-reflective environment, is my most incredible privilege. Everyone can benefit from an environment where every experience becomes a skill and tool for personal growth and better customer service.

Rosario Gullota

The Trust has a mantra, 'What we do together matters,' which is fundamental in creating a safe, secure and new approach to the care given at EPUT because safety and care go hand in hand, and it's 100% correct that this is an essential issue for us all. Together we can create a safe environment for all, learning from the past, embedding the voices in the present, collectively and securing an environment of resilience, responsibility, and safe practices for the future.

Mark Dale

FOREWORD

(See pgs.01-06)

One of the key objectives of the EPUT Culture of Learning (ECOL) is to improve the quality of care and safety for everyone. We aim to do this by sharing learning not only when things go wrong, but also by identifying and replicating areas of excellent practice, both within EPUT and in the wider health economy.

Our philosophy is based on the principles of a Just, Caring and Learning Culture, where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed.

EPUT is committed to making improvements in systems and processes identified through patient safety incident reviews, coroner's inquest, complaints, claims and patient experience. This will be reflected in the Trust's governance arrangements, and we aim to build on this to ensure learning lessons is embedded across every part of the organisation and in every aspect of its work.

Moriam Adekunle – Director of Safety and Patient Safety Specialist
AUTHOR

FOREWORD

CARE UNIT LEADERSHIP TEAM

(See pgs.01-06)

Alex Green
Executive Chief Operating Officer

Elizabeth Wells
Director Mental Health Urgent & Inpatient Services Trust Wide

Lynnbritt Gale
Director South East Essex Delivery & Partnerships

Greg Wood
Clinical Director Psychological Services

Emma Strivens
Director North Essex Community Delivery & Partnerships

Nicole Rich
Director West Essex Community Delivery & Partnerships

Ian Carr
Director Specialist Services

FOREWORD

(See pgs.01-06)

CARE UNIT COMMITMENT

Patient safety and the well-being of our staff are at the heart of how we deliver the highest quality of patient care and experience. The Trust's Care Units' Leadership Team is committed to identifying, sharing and implementing learning wherever we find it. The EPUT Culture of Learning and the Lessons Team gives us the framework to deliver this aspiration.

The habits and behaviours of every staff member across the organisation will bring the learning to life, from Directors to Service Managers, Team Leaders, Medical and Allied Health Professionals and support staff. We will all remain committed to improving the quality and safety of services for those who rely on us. We will fully support and engage with the work of the Lessons Team to ensure that learning lessons is an embedded part of our culture, and that we are actively improving how we deliver care and treatment across the Trust.

FOREWORD

(See pgs.01-06)

LESSONS TEAM SHAPING THE FUTURE OF LEARNING

Learning lessons is of prime importance to our Trust, and we all have a responsibility to seek improvement, learn from mistakes or good practices and adopt positive changes to provide safe and excellent care. The EPUT Culture of Learning (ECOL) represents our commitment and willingness to learn from the experience of others. The framework will enable us to achieve the Quality of Care Strategy outcomes.

The Lessons Team is integral to ensuring learning lessons become an ‘Always Event’ in EPUT. We understand the complexity of working in healthcare; it is highly variable, dynamic, and characterised by multiple interactions between human and technological components. We believe the work system components should support the person to do the work to the best of their ability.

Members of the Lessons Team will champion the culture of learning and are committed to creating the conditions that will support effective learning and embed change in practice. The Lessons Team work with all teams and Subject Matter Experts to innovatively consider how learning can be captured, analysed, raised or resolved, and embedded within a practice.

For further information please contact the Lessons Team at: epunft.lessonsteam@nhs.net

CULTURE OF LEARNING

(See pgs.07-09)

MINIMISE THE RISK OF HARM

To patients, families, and the workforce

BEHAVIOUR EXPECTATIONS

JUST CULTURE

LEADERSHIP DEVELOPMENT

BOARD ENGAGEMENT

TRUST, RESPECT, AND INCLUSION

VISION

For learning lessons to become an ‘Always Event’ at EPUT

INTRODUCTION TO

EPUT CULTURE OF LEARNING (ECOL)

The Learning Lessons Handbook provides a framework within which all lessons can be captured, analysed, resolved, and embedded within the Trust. Success in implementing ECOL will allow us to leverage the full potential of both our workforce and the organisation.

ECOL is wholly reliant on the adoption of appropriate behaviours across the entire workforce and the creation of a culture in which the drive for continuous improvement is automatically recognised as an integral part of everyday working. Every directorate lead and line manager has a leadership role to set an example and to actively encourage, support, and reward the application of ECOL at every level of the organisation, from every ward, team, department, staff member and contractor to the most senior leader.

CULTURE OF LEARNING

(See pgs.07-09)

SCOPE

ECOL applies to all people employed in any capacity by Essex Partnership University NHS Foundation Trust in its entirety across all demographics in the organisation.

AIM

This procedural document aims to describe the constituent parts of ECOL and assign roles and responsibilities to all who contribute to and support the process. The procedural document endorses delivering the ambitions cited in the Quality of Care Strategy and National Patient Safety Strategy.

TARGET AUDIENCE

All staff working for Essex Partnership University NHS Foundation Trust.

STRATEGY

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STRATEGY

LEARNING BY ALL

ECOL is a directorate led activity which must be incorporated within all aspects of the Trust business. ECOL is not, however, an administrative process that only concerns a select number of individuals that have 'lessons' in their job title; neither is it a secondary duty that a care unit can give to one nominated individual. Taking the time to pause, reflect and consider whether we can improve the way things are currently done must become a fundamental driver for all members of staff, no matter their role or seniority, and must take place continuously at both an individual level and a team context.

LEADERSHIP

The role of directorate leads and line managers at all levels in cultivating and sustaining a learning culture is crucial. Genuine leadership is required to drive and stimulate lessons-focused activity and to acknowledge and reward the achievements made. Leaders must also allow staff to build time into their processes and ward / service activities to review and reflect on activity, stressing the longer-term benefits that will come from investing energy into learning and improving. Leaders must recognise and embrace the learning opportunities that come from errors and mistakes, seeing them not as failures, but as opportunities. A guide to 'what good looks like' for leaders at all levels is available in **Appendix A**.

STRATEGY

(See pgs.10-24)

PRINCIPLES

THE FOLLOWING BROAD PRINCIPLES UNDERPIN THE IMPLEMENTATION OF ECOL:

- Participation in ECOL is the responsibility of everyone, irrespective of band or grade, and is operationally led.
- ECOL is part of business as usual for us as an organisation. The mechanisms for resolving issues identified through ECOL should be incorporated into existing reporting, governance, accountability framework and assurance mechanisms.
- ECOL is fundamentally a collaborative process; very rarely will a single individual spot a problem, devise the optimum solution and be able to implement the required change by themselves. By exchanging ideas and seeking out the contribution of those who can offer a different perspective, we are far more likely to identify genuine improvements that are sustainable in the longer term.
- At its heart, ECOL is also a bottom-up process; those at the frontline who deliver an effect on the ground are likely to be best placed to understand what works, what adds genuine value as well as what could be done better. Just as importantly, they are most likely to understand how the unintended consequences of a well-intentioned policy or procedural guideline may be hampering our effectiveness.
- The process of turning lessons into improvements must be agile and responsive, employing the minimum amount of staff effort to realise the benefits identified without unnecessary delay. This includes the processes required to escalate lessons to an appropriate level in leadership team; when lesson originators/owners are unable to progress the issue further by themselves.
- The context in which care is delivered is variable, and an overly prescriptive process is likely to prove counter-productive. In view of this, the administrative demands placed on lessons originators to process lessons identified should be kept to the absolute minimum.
- Feedback to the originators of lessons is crucial; faith in the process will be lost if lessons that cannot be resolved at the point of origin and require action from the senior leadership team are perceived to disappear into some 'black hole' with no discernible action having been taken.

STRATEGY

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BENEFITS

THE BENEFITS THAT WILL BE REALISED FOR BOTH THE ORGANISATION AND OUR PEOPLE THROUGH EMBRACING ECOL INCLUDE:

1. Making activities safer, through better identification of risk and the active reporting and management of near misses.
2. Increasing the likelihood of success in the completion of tasks and activities our teams engage in.
3. Minimising the risk of reputational damage for the Trust by averting failure, in whatever form, before it happens.
4. Maximising positive engagement outcomes through the active promotion of EPUT's reputation as a learning organisation.
5. Saving time, resources and finances, which can be reinvested in both local and strategic priorities.
6. Improving morale by making processes less time-consuming and/or bureaucratic, thereby breaking the cycle of frustration and freeing time to be spent on more productive activities.
7. Providing opportunities for individuals to engage in a creative and stimulating aspect of their role that can improve job satisfaction and help with people development. This will enable us to attract and retain the best talent at EPUT and consistently deliver outstanding care.

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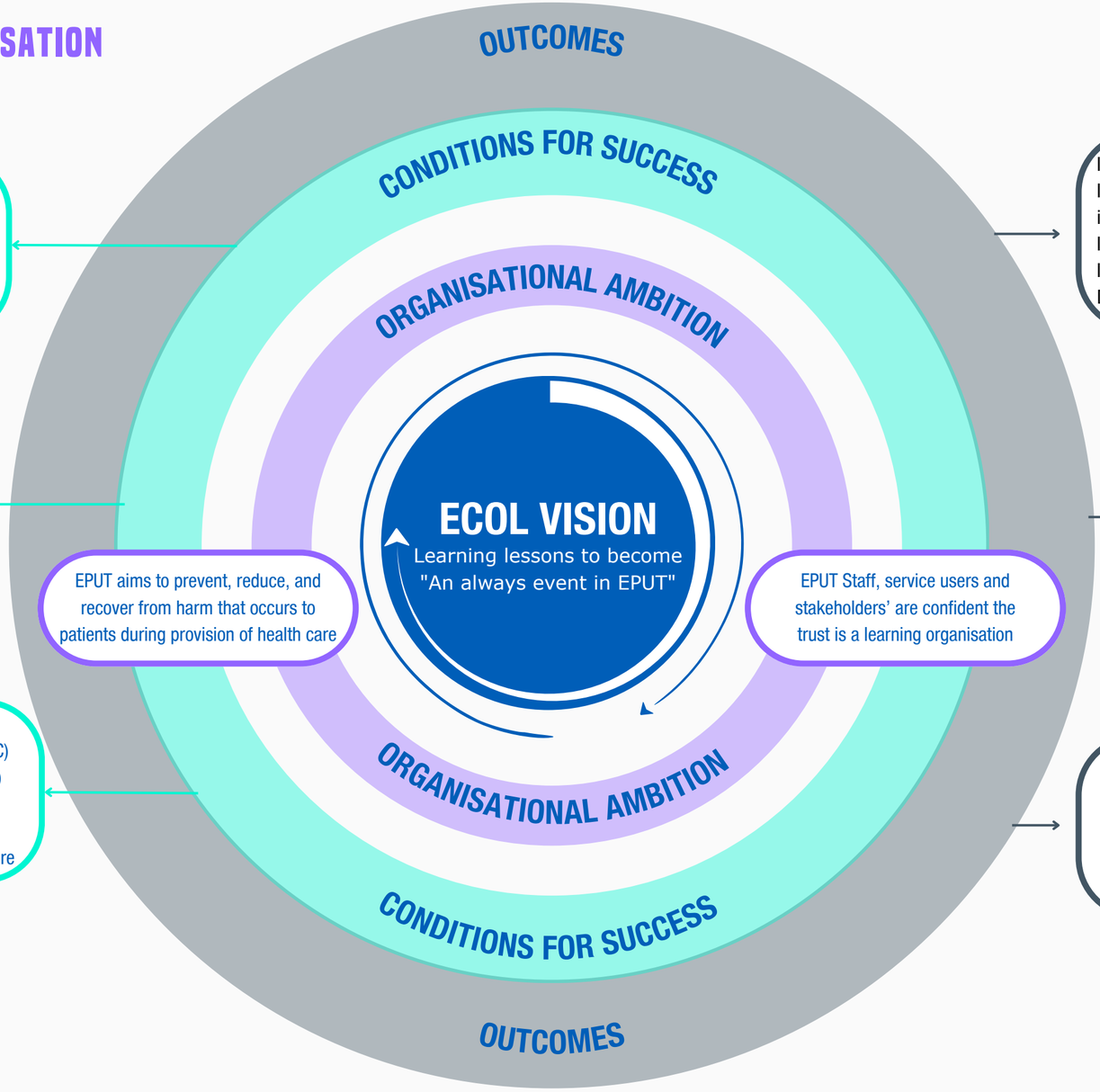
QUALITY BENEFIT REALISATION

Cascading Information
Redesign 5 Key messages, Webinars & Newsletters
Develop a Trustwide Lessons Training
Care Unit Live Learning Events
Embed Just, Caring and Learning Culture

Digital Systems & Tools
Improve data collection on Datix
Develop a Safety Dashboard
Develop a Safety & Learning Management System

Organisational Structure & Processes
Revise the Learning Oversight Sub Committee (LOSC)
Convene a Learning Collaborative Partnership (LCP)
Develop a Learning Lessons Handbook
Implement Lessons Team intervention
Develop sustainable Quality Improvement infrastructure



Improvement in quality of information collected via Datix
Improved visualisation of amalgamated data from different intelligence sources
Improvement in reporting of incidents
Improvement in Lessons identified from incidents recorded on DATIX

Dedicated resource to improve organisational learning
Develop a procedural document for learning lessons
Establish governance structure to support identification and cascading of lessons
Establish governance process for LOSC & LCP meetings
Establish Quality and Safety (Q&S) Champion Network

Improved Trust-wide learning events and create space for learning
Improved shared learning resource
Improved level of engagement with cascaded learning resources
Improved analytics for cascaded lessons information

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C.A.R.E MODEL PROCESS

ECOL is not a complicated process. The steps of Capture, Analysis, Resolution and Embed (C.A.R.E) are likely to apply in one form or another to every lesson but these should be interpreted as broad principles to be followed rather than a strictly sequential set of activities that must be followed in every instance.

CAPTURE

This is undertaking a conscious period of reflection and/or local investigation to understand what issues arose during the execution of a task, and then recording the details of the issues identified and good practice, so the opportunity to make an improvement is not lost. Capturing the information within one central log, such as Datix, will help the local services and the wider organisation to be aware of incidents and events.

ANALYSE

Utilising tools to establish the analysis will support with the introduction of effective actions related to the desired outcome and will empower staff to take ownership and use this intelligence within their role.

RESOLVE OR RAISE

This involves taking the necessary action to implement the change required. Learning is locally managed and resolved for actions to be implemented. It is important for the resources (personnel or finance) are made available to the team to implement the change. Where lessons can not solely be managed locally, they are raised in appropriate forums and allocated to an action lead to drive the change forward.

EMBED

A number of mechanisms have been developed for the cascade of lessons identified in the Trust and are stored on the Trust's Culture of Learning intranet page via the desktop icon. Embedding of learning provides empowerment for local services and the wider organisation to discuss the identified learning and consider how this can sustainably change practice. Furthermore, it ensures any changes are communicated to those who need to know, and are reflected within policy, protocol and procedural documents.

MORE GUIDANCE ON THE CARE STAGES IS PROVIDED IN APPENDIX B.

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OWNERSHIP

For the majority of lessons it is likely that the team that initially identifies the issue will also be best placed to carry out all of the capture, analysis, resolution and embedding steps. That team will therefore 'own' the lesson across all stages of the process. As noted above, however, there may be instances where escalation to the senior leadership team or the Executive Team is required and at this point, ownership of the lesson can be said to have been transferred to another team or a responsible person that will now take the next steps towards resolution.

ESCALATION

When lessons are escalated, the senior managers within the directorate must look to add value by building upon the analysis undertaken by the originator rather than simply taking the initial conclusions and recommendations at face value. The need for escalation is a good indicator that there may be other, wider factors that need to be considered that were not necessarily visible to the originators. The higher-level analysis might therefore arrive at a different conclusion regarding either the validity of the original issue or the best way of bringing about the desired change. The higher-level analysis might also conclude that the lesson being reported is a symptom of a much wider systemic issue that requires a radically different route to resolution. Further guidance on the analysis that may be required is contained within **Appendix B**.

MEDIATION

The process of analysis should include all relevant stakeholders and aim to reach a consensus regarding both the appropriate way forward and the team that will lead on implementing the change and therefore take subsequent ownership of the lesson. There may, however, be some instances where consensus on the issue cannot be reached. Should subsequent dialogue between the parties be unable to resolve the impasse, this should be resolved by further escalation to the Learning Oversight Sub-Committee (LOSC) or other appropriate sub-committee who will convene a meeting inviting all relevant parties to resolve the issue. The steps involved in the escalation and mediation process are set out in **Appendix C**.

LESSONS ANALYSIS

To support the directorate leads in executing ECOL as efficiently and effectively as possible, we have identified Learning Collaborative Partners (LCPs) who are Subject Matter Experts (SMEs) within existing specialist and support teams in the generation of lessons as they relate to certain specific activities. These activities are generally those issues of a more serious nature i.e. where either some form of formal investigation is required following an incident or there is a Serious Risk to Life (SRtL) or reputational aspect to the activity in question. The network of LCPs is described in **Table 1**.

Note:
*The process described under mediation assumes that the lesson identified relates to a negative issue that requires resolution, but the same approach can be taken where the lesson has identified an example of good practice that needs to be shared and/or become incorporated into standard operating procedures.

The Local Lessons Log (L3) template can be generated as a report on DATIX. Issues of a more serious nature will be captured in EPUT Safety and Lessons Management System (ESLMS) and made available on the Culture of Learning desktop icon, see **Appendix D.

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EPUT LEARNING COLLABORATIVE PARTNERS

The precise role for each LCP member will vary in relation to their specialist area and the context in which lessons are identified. At a minimum each member has a remit to ensure emerging themes are identified and resolved in a timely and efficient manner. It is important to maintain consistency with how lessons that fall into their Area of Responsibility (AOR) are dealt with.
This may include direction on:

- Any specific thresholds or circumstances above which lessons must be reported to the Learning Collaborative Partnership, whether for action or information.
- Any specific format in which lessons are to be captured and/or any specific reporting or investigation tools that should be used.
- Any relevant timescales in relation to the original event or activity in which lessons are to be reported and to whom.

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EPUT LEARNING COLLABORATIVE PARTNERS

- Allied Health Professionals
- Care Group - Community Delivery & Partnerships Mid and South Essex
- Care Group - Community Delivery & Partnerships North Essex
- Care Group - Community Delivery & Partnerships West Essex
- Care Group - Inpatient & Urgent Care
- Care Group - Psychological Services
- Care Group - Specialist Services
- Claims, Legal & Inquests
- Clinical Audit
- Complaints / PALS
- Compliance & Emergency Planning
- Datix / Risk Management / Health and Safety
- Digital (Information & Technology)
- Equality and Inclusion
- Estates and Facilities
- Finance
- Freedom to Speak Up
- Human Resources and Staff Side Leadership
- Infection Prevention & Control
- Information Governance
- Inquest Team
- Learning and Development
- Learning from Deaths
- Medical
- Medical Devices, Physical Health & Resuscitation
- Medical Staffing
- Patient Experience Team & Compliments
- Patient Safety Incident Management (PSIM)
- Patient Safety Partners
- Performance Team
- Pharmacy & Medicines Management
- Safeguarding
- Transformation
- Violence and Abuse Prevention Reduction

STRATEGY

(See pgs.10-24)

THE LEARNING COLLABORATIVE PARTNERS WILL:

1. Support the Directorate Leads in executing the EPUT Culture of Learning as efficiently and effectively as possible.
2. Champion the EPUT Culture of Learning and provide advice and guidance to those most likely to be affected by issues that fall into their area of responsibility.
3. Take ownership and provide expertise as Subject Matter Experts (SMEs) with existing specialist teams in the generation of lessons that fall within the thresholds **outlined in item 3 of appendix D** for their area of responsibility and manage these in the subsequent lesson analysis phase.
4. Review and discuss learning in aggregate from good practice, incidents, including patient safety incidents, complaints and patient experience.
5. Recommend whether a lesson is of sufficient importance to be escalated to the Learning Oversight Sub-Committee.
6. Maintain oversight of the totality of lessons identified in their area of specialism to spot emerging trends and themes that may not otherwise be visible to the leadership team and develop a process for the cascading of such lessons.

STRATEGY

SAFETY AND LEARNING COMMAND CALL (SALC CALL)

(See pgs.10-24)

This flow chart shows the process in which the Lessons Team will coordinate and follow, with support from operational colleagues.

New or significant opportunity for learning identified.

For PSI related incident, PSIM Team to arrange a swarm huddle within 24 hours of the event occurring if within the hour and first working day if out of hours. The early learning will be drawn from the swarm huddle.

Lessons Team to stand up Safety and Learning Command call. The SALC Call is to occur within 48 hours of the identification of new and significant learning.

SALC Call to be chaired by the Lessons Team with input from DDQSs and/or subject matter experts. Meeting to provide overview of the event and identification of early learning.

SALC Call members to determine the method of lessons cascade. This may include a Safety Learning Alert, Lessons Briefing, Learning Matters live session, or inclusion in the Lessons Identified Newsletter or 5 Key Messages.

Safety Learning Alert Content to be agreed by the Lessons Team and subject matter experts. Content to be made into digital and poster version by the Lessons Team Communications Business Partner. To be completed the same day as the SALC Call.

Lessons Briefing content to be agreed by SALC Call members, and made into digital and poster versions of the Briefing. Group to determine the use of a 10 minute Trust-wide live briefing alongside the poster. To be completed within 5 working days of the SALC call.

Non-immediate learning may be incorporated into the next Lessons Identified Newsletter or 5 Key Messages, as agreed in the Learning Collaborative Partnership Group (LCP).

Draft version to be approved by Functional Lessons Analyst and Head of Shared Learning and/or Nurse Consultant for Patient Safety.

Final Safety Learning Alert to be shared with Datix Team - epunft.risk@nhs.net. They will require details of who the alert is to be shared with. Datix Team to cascade the alert within 2 working days of receipt.

Lessons Team to attend relevant sit rep calls to share content of the Safety Learning Alert. To be completed within 2 working days of the alert being finalised.

Lessons Team to follow first and second line assurance testing processes.

When a new or significant learning opportunity is available, which should be widely shared, the Lessons Team will work with Subject Matter Experts to generate a Safety Learning Alert which will be shared via Datix with managers who are required to cascade information and provide assurance that action has been taken where appropriate.

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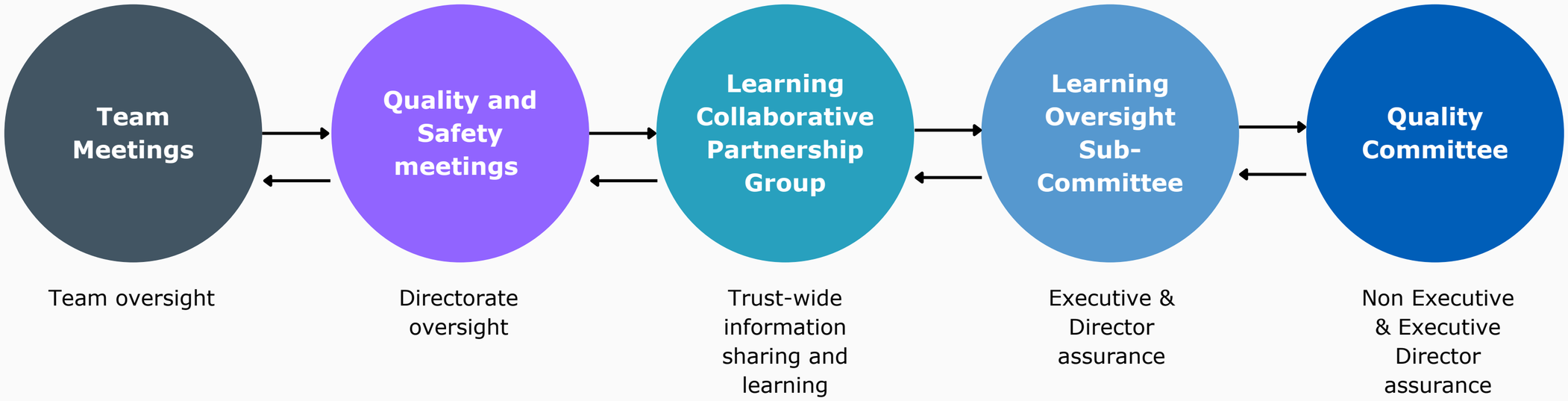
ASSURANCE AND GOVERNANCE

The Lessons Team recognises the value of collaborating and sharing information regarding incidents and prevention strategies. This facilitates the development of best practices and the implementation of consistent safety measures across different areas and settings within the trust. Some key governance meetings allow us to deliver on this including the Learning Collaborative Partnership (LCP). Essential to this, is how these meetings feed in to each other to ensure the continuous monitoring and evaluation of risk measures through inspections, audits, and assessments. These are necessary to identify any new or significant risks that may arise and to ensure that existing prevention strategies remain effective.

EPUT Lessons Analysts are a small team of analysts (Functional and Lessons Analysts) who act as the conduit between the LCPs, corporate and support services, the care units and directorate leads. They contribute to the mediation process when lessons generated in one area require action in another and there is a lack of consensus on the way forward. A simple flowchart that shows the steps for escalation and mediation once a lesson has first been identified is attached in **Appendix C**.



The learning opportunities from key discussions in LCP are reported into the Learning Oversight Sub-Committee, shared in the monthly Lessons Identified Newsletter and 5 Key Messages, which is shared within the Quality Committee. More information can be viewed in the LCP Terms of Reference.

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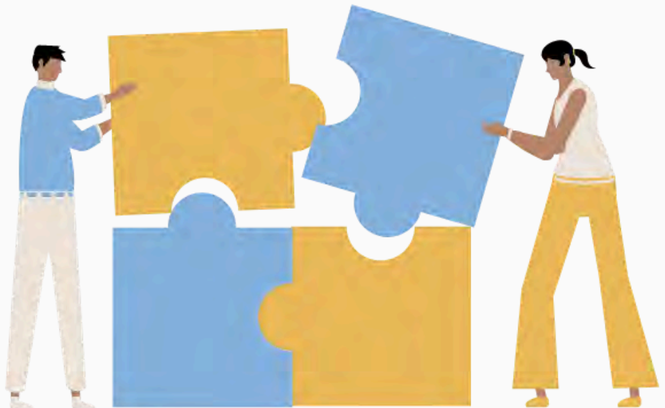
ASSURANCE AND GOVERNANCE

Assurance of ECOL is provided as follows:

a. The Care Unit leads will undertake the first line of assurance i.e. Directorate leads, Associate Directors and Operational/Service Managers at all levels will ensure Matrons, Ward and Team Managers are actively taking steps to identify lessons as part of normal business activities and ensure Local Lessons Log (L3) report is generated on DATIX and reviewed in the team meeting as a standing agenda item.

b. Second line of Assurance of ECOL is to be undertaken by:

- The relevant LCPs, from the production to the implementation of lessons in relation to activity that falls into their area of responsibility.
- The EPUT Lessons Analysts will assure the lessons processes in place in each care unit through a range of mechanisms and be available to provide advice and assistance to front line teams (subject to capacity) as requested by the Directorate Leads or Director of Patient Safety & Patient Safety Specialist.



As part of the governance arrangement, the Lessons Team will meet with the Executive Chief Nurse, Chief Operating Officer and Executive Medical Director on a quarterly basis, with input from the Learning Oversight Sub-Committee Chair. The primary purpose of this review is to:

- Consider the overall effectiveness of ECOL, sharing best practice and identifying areas for improvement.
- The Patient Safety Specialist and Patient Safety Partners will work collaboratively with the Learning Oversight Sub-Committee and hold the directorate leads to account for resolving those lessons of sufficient importance that have therefore warranted being added to ESLMS or the Trust-wide Safety Improvement Plan (see **Appendix D**).
- Give the Executive Directors sufficient insight into the operation of ECOL that can inform the briefing to the Quality Committee (QC) and the Trust Board.

STRATEGY

(See pgs.10-24)

STAFF SUPPORT

Embracing a Just, Caring and Learning Culture will create an environment where it is safe for staff to report concerns, engage in reviews and share learning without fear of blame or criticism. EPUT is committed to supporting staff involved in or affected by incidents through prompt and effective debrief and access to emotional support.

We will develop innovative ways to engage staff at all levels in learning, with an increased focus on technological solutions to disseminate learning.

The EPUT Lessons Facilitator delivers training on a range of topics to operational leads, clinical leaders, management staff and DATIX handlers to support use of the Systems Engineering Initiative for Patient Safety (SEIPS) principles and develop their skillset in identifying lessons. Gaps in training identified from investigation reports and reviews, inquest, complaints, compliments or feedback from patient experience are escalated to the EPUT Lessons Team through the Learning Collaborative Partnership meeting. Where a training need is identified, the learning and development department or relevant Subject Matter Expert will ensure appropriate training can be commissioned and prioritised for the relevant staff groups.

Learning cascades will highlight systems learning in an anonymised way which does not target individuals, teams or directorates.

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CHAMPIONING SAFETY AND LEARNING

Quality and Safety Champion

The quality and safety champions are volunteers who are passionate about patient safety, and committed to the delivery of high quality care in the Trust. They lead, co-facilitates or supports the implementation of continuous improvement and embedding of learning within their service.

The quality and safety champions will:

- Advocate and strengthen a positive quality and safety culture by routinely engaging team colleagues in learning conversations and referencing the EPUT's shared learning resources.
- Share learning from Patient Safety Incident investigations with colleagues in their service through the course of their routine work and lead by example in order to positively influence patient safety and quality of care directly.
- Ensure safety, learning and quality remains a standing agenda item in the service team meetings.
- Support the embedding of learning from a range of sources into practice within your team and contribute towards organisational systems which will evidence that learning has occurred locally, as part of a wider function across the organisation.
- Network and work in partnership with colleagues from the Patient Safety Incident Management Team, Risk and DATIX Management Team and Inquest Services Team.
- Participate in quality forums relevant to their service.

Freedom to Speak Up

As NHS staff, we all have a professional duty to report concerns about anything happening at work that may put the safety of staff, the public or people we look after at risk.

When things go wrong, we need to make sure that lessons are identified and changes embedded for system improvement.

Speaking Up, Listening Up and Following Up align with our organisational values and, if we are not doing these things, we are not truly embracing the values.

The Trust have a Principal Freedom to Speak Up and local guardians who proactively work to support staff in tackling the barriers to speaking up.

Contact Freedom to Speak Up:

- by email: f2su.eput@nhs.net
- by anonymous web submission form
- by contacting one of our local guardians

For more information visit the Freedom to Speak page on Input.

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STAKEHOLDER ENGAGEMENT

Our most important stakeholders are our patients, service users, carers and relatives who may have been impacted by a patient safety incident. We will acknowledge when things have gone wrong, offer an apology and always involve them in the incident review process, to ensure that we focus on the things that are important to them.

We will work with partner agencies to develop a robust process that promotes and supports joint reviews and Safety Improvement Plans that effectively address systematic failures across services and pathways.

We will ensure that EPUT is always represented at Integrated Care System (ICS) / Integrated Care Boards (ICB) and Regional / National Patient Safety Partnership meetings to ensure effective multi-agency learning and planning.

We will benchmark our learning against nationally published statistical reports, investigations and reviews and ensure recommendations are implemented in the Trust to help improve practice.

GLOSSARY

(See pg.25/25)

LCP
Learning Collaborative Partnership

LOSC
Learning Oversight Sub-Committee

ELA
EPUT Lessons Analysts

SME
Subject Matter Expert

ECOL
EPUT Culture of Learning

ICS
Integrated Care System

C.A.R.E
Capture, Analyse, Resolve/Raise and Embed

PSIM
Patient Safety Incident Management

L3
Local Lessons Log

SRTL
Serious Risk to Life

ICB
Integrated Care Board

ESLMS
EPUT Safety and Lessons Management System

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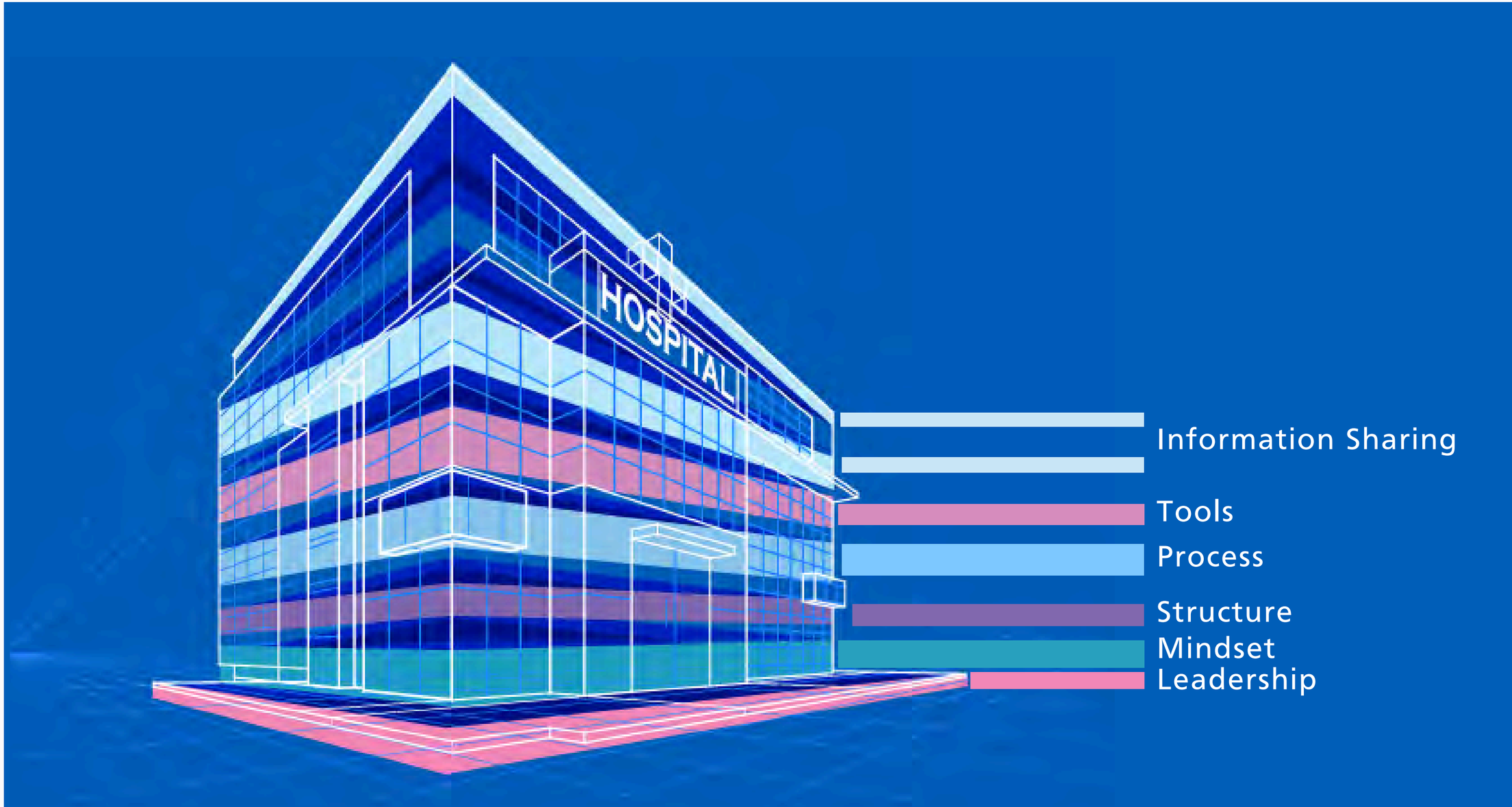
APPENDIX A LEADERSHIP IN SUPPORT OF THE EPUT CULTURE OF LEARNING (ECOL)



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APPENDIX A LEADERSHIP IN SUPPORT OF THE EPUT CULTURE OF LEARNING (ECOL)

ECOL is a directorate led activity, where every director, line manager and staff are required to engage, and encourage their teams on a regular basis to review the way they are delivering their duties.

ECOL is less about process and more about culture and behaviours. Leadership is therefore crucial. All senior staff who have a management responsibility for our people irrespective of the level, are required to act as a role model and visibly champion the importance of ECOL by taking the following steps:

Induction - On arrival in a new role and location, leaders / managers must ensure that all new staff:

- Receive a briefing to stress the value and benefits of ECOL and Continuous Improvement as set out in this document.
- Understand how the CARE approach is adopted in their new environment and the role they play within it.
- Receive a handover pack that includes the top ten lessons identified which directly impacts the service area or relevant to their new role.
- New managers will be briefed on the specific responsibility they have for resolving a lesson that has been identified whether in a Local Lessons Log (L3) on DATIX or in EPUT Safety and Lessons Management System (ESLMS).
- To ask for feedback on how the induction process can be improved from inductees.
- Managers to set specific personal objectives for staff that describe the role they are expected to play in ECOL as part of the annual appraisal process.

Internal Process - As part of the established routine or internal process for their team, leaders are to set an example by:

- Adding a review of lessons to the agenda for all team and business meetings, covering both new improvements that have recently been added to the Local Lessons Log (L3) on DATIX by the team and asking for updates on local improvements that are in the process of being implemented.
- Where previous lessons have been identified by the team and escalated up to the directorate senior leadership team for action, the team should be updated on any progress made.
- Reflections on the effectiveness of the meeting should be a standing agenda item for all team and business meetings and attendees should be actively encouraged to suggest improvements for next time.
- Ensure protected time is allocated to the Quality and Safety Champions to support their teams and the support required is taken into account in their personal and professional development plan.

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APPENDIX A LEADERSHIP IN SUPPORT OF THE EPUT CULTURE OF LEARNING (ECOL)

Tasking - when setting new tasks and challenges, leaders / line managers are to:

- Encourage the team members to seek out lessons from colleagues in services outside of their immediate team within the organisation and to report back both what they have found and how this could be reflected in their day to day practice.
- Set the requirement to reflect and capture lessons identified at key points in the delivery of a task or activity, this discussion can take place during handover, Safety Huddle or multidisciplinary team meeting and taken to the team business or operational meeting for a wider discussion.

Inspire and Encourage - leaders / line managers are to actively:

- Challenge staff to question the assumptions that drive the way they do their work, particularly when it comes to perceived constraints and barriers.
- Take an interest in both the improvements staff are identifying and the processes that they are using to identify lessons.
- Promote the personal development opportunities associated with continuous improvement activities e.g. using quality improvement methodology to address a problem, encouraging staff to step outside of their comfort zone to identify both issues and solutions.
- Set aside time for team reflection and team building exercise, highlighting the importance of learning when set against other perceived priorities.
- Make reflection and learning events fun and engaging, so that team members look forward to the process and have the opportunity to be creative.
- Provide an environment in which staff can be open and honest about where they have struggled and/or been unsuccessful to ensure that relevant lessons can be identified. Ensure the principles of a Just, Caring and Learning Culture is followed when things go wrong.
- Recognise that failure is a normal and important part of training, development and learning and ensure that it is viewed positively as an opportunity.

Reward and Recognition - leaders and line managers should:

- Publicly celebrate success in the improvements identified, nominating the team for awards internally, locally, regionally, and nationally.
- Use the Staff Recognition Scheme to reward those that have made valuable contributions to continuous improvement and ECOL.

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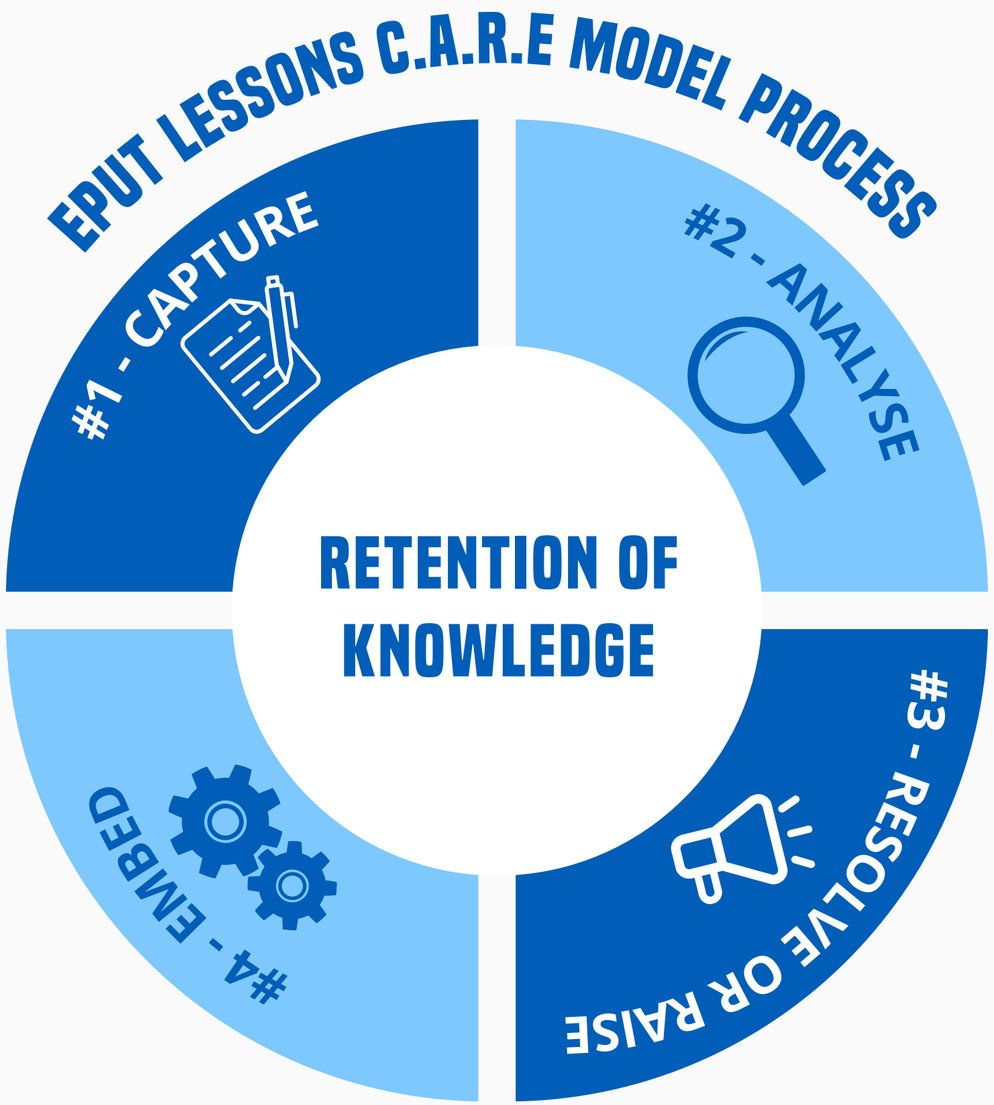
APPENDIX B EPUT CULTURE OF LEARNING (ECOL) – C.A.R.E. PROCESS OVERVIEW



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APPENDIX B EPUT CULTURE OF LEARNING (ECOL) – C.A.R.E. PROCESS OVERVIEW

Lesson Capture

Lesson capture involves the initial identification of a lesson and the recording of that lesson in a suitable repository.

Identification

Lesson identification can take place at any time and in any context and could, for example, be:

- As a result of a team meeting
- In response to a specific incident or event
- At the completion of a project, event or task
- As part of a scheduled review of ongoing activity
- By reviewing the lessons already identified and logged on ESLMS (see Appendix D)

Lesson Analysis

Purpose

Lesson analysis is characterised by the introduction of additional perspectives that can add value to refine the initial understanding of:

- The contributory factor(s) of the issue
- The most appropriate actions or recommendations
- Those who are best placed to take forward those actions or recommendations
- Whether there are wider trends or themes that need to be addressed

Originator Analysis

Where the lesson identified is straight-forward and the required actions can be taken forward by the originating team without further escalation, there may be no need for further analysis beyond that already undertaken. A second level analysis can still be undertaken by the originating team, and the value of having somebody informally review your own conclusions should never be under-estimated; a second pair of eyes will nearly always open up other avenues for consideration and improve the richness of the learning experience.

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APPENDIX B EPUT CULTURE OF LEARNING (ECOL) – C.A.R.E. PROCESS OVERVIEW

Escalation to the Learning Oversight Sub Committee (LOSC)
Additional analysis will nearly always be required if the team that originally identified the lesson have concluded that the improvement action is beyond their ability or authority to implement. In these circumstances, the lesson will have been escalated to either the appropriate level in the senior leadership team or a relevant Subject Matter Expert via the Learning Collaborative Partnership Group (LCP). Whoever has assumed ownership at this point will lead the analysis phase and will request a review by the LOSC where this is deemed appropriate.

ECOL must provide a swift and agile response to lessons identified, and any mediation meeting by LOSC should be convened as quickly as possible. Short, informal meetings and out of Sub-Committee working is always preferable to formally established meetings scheduled as part of internal process.

Lesson Resolution

Lesson resolution is the part of the process where the changes or actions identified are assigned to an individual and implemented. Once the action has been completed for a patient safety incident that meets the local or national criteria in the Patient Safety Incident Response Plan (PSIRP), this should be cascaded to the relevant services.

Lesson Embedding

Lesson embedding is the final, crucial phase aimed not only at spreading insights about changes, their implications and impact but also at integrating these lessons into practical service-level applications. This dissemination targets stakeholders ranging from teams to wider professional communities and Trust affiliates. It goes beyond sharing information, involving active integration of knowledge for practical use. This process often employs proactive 'push' and receptive 'pull' strategies for broader audiences.

a. 'Push' communication actively targets those that need to be aware of the change. This style of communication is likely to represent a 'one off' opportunity to share the message and there is always a risk that the message might fail to register with some individuals. It should also be remembered that even if the initial message landed successfully with large numbers of the target audience, awareness will still fade over time.

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APPENDIX B EPUT CULTURE OF LEARNING (ECOL) – C.A.R.E. PROCESS OVERVIEW

Consideration might therefore need to be given to a more sustained form of campaign. Push channels can include:

1. E-mails.
2. Briefings
3. Induction Checklist
4. Targeted newsletters and key messages
5. Inclusion of information in formal course content (e-learning and face to face)
6. Safety Action Alerts

b. 'Pull' communication involves the updating of all relevant documentation or other resources and making them easily accessible so that an individual who actively goes looking for relevant guidance can find – or 'pull' – what they are looking for. Pull channels will invariably involve information that is accessible to users on the intranet and may include a mixture of formal policy, documents, and guidance.

You'll notice the "Culture of Learning" desktop icon on all Trust computers. With just one click, you can easily access important learning materials and publications from across the Trust.

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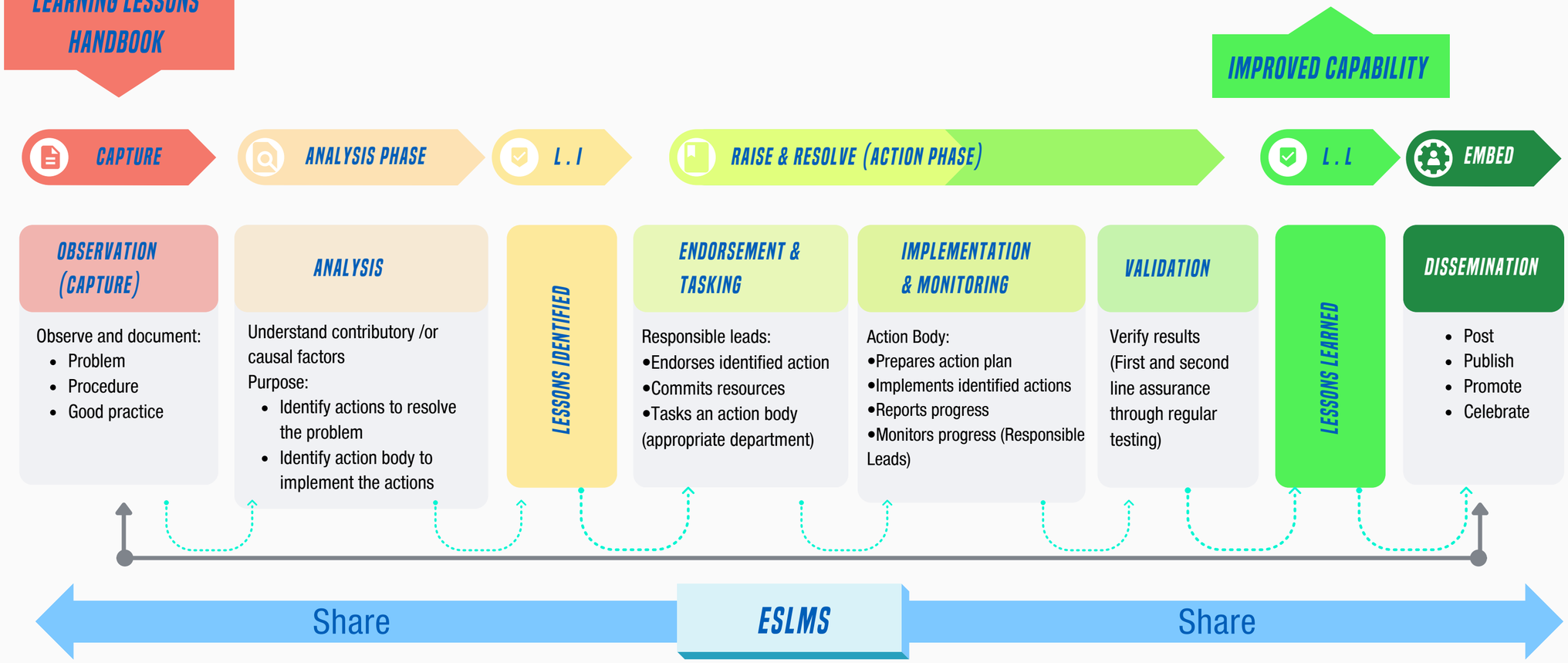
APPENDIX B EPUT CULTURE OF LEARNING (ECOL) – C.A.R.E. PROCESS OVERVIEW



Adapted from the NATO Lessons Handbook

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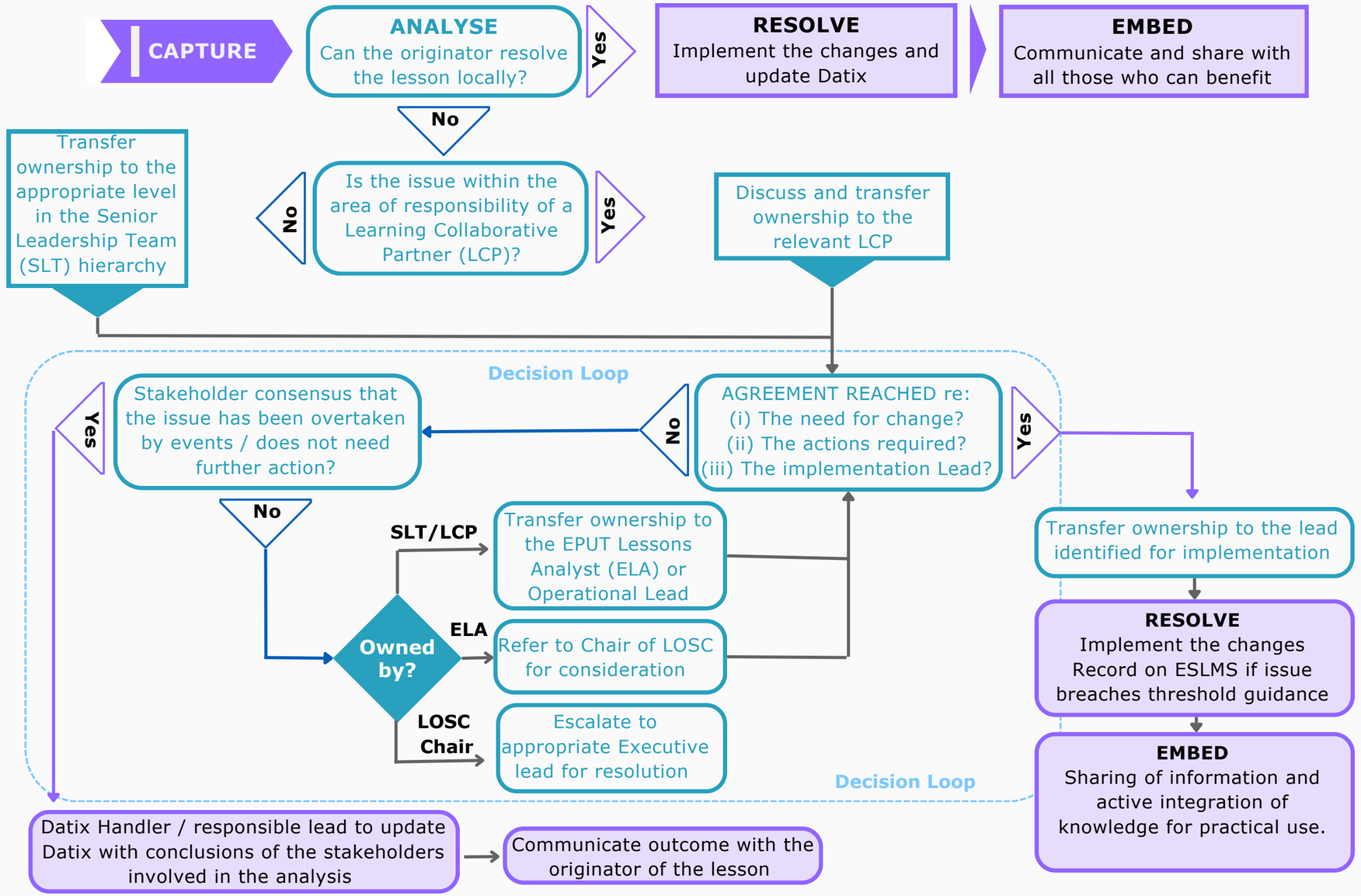
APPENDIX C ECOL ESCALATION AND MEDIATION PROCESS



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APPENDIX D EPUT SAFETY AND LESSONS MANAGEMENT SYSTEM (ESLMS)

1. The EPUT Safety and Lessons Management System (ESLMS) is a database of Lessons Identified from a range of sources that will be aligned to the Safety Improvement Plan under the Patient Safety Incident Response Framework (PSIRF). The system is designed to serve as a deterrent for incidents occurring again, or at least ameliorate their effect by creating an opportunity for learning from near misses and good practice to be shared with the workforce.

2. The benefits of using ESLMS include the ability to:
   - Create a permanent audit trail that details every action taken to resolve a lesson in a system that can be interrogated by any authorised user in the Trust.
   - Add comments and supporting files to the audit trail.
   - Allocate a status to the lesson and track ongoing progress through to closure.
   - Assign the lesson to both a nominated Action Body Lead that will own it and the individual(s) who have been given specific responsibility to take further action.

3. In addition to learning from Datix incidents, which are harvested automatically, lessons from other sources will be manually added to ESLMS where there is a significant opportunity for learning that:
   - Has resulted in death or serious injury.
   - Represents a near miss or high degree of risk of further death or serious injury.
   - Results in financial write-off as losses.
   - Is the result of fraud.
   - Equates to a failure to achieve a stated operational aim.
   - Relates to a breach of the Trust's Information Governance Policy.
   - Relates to a breach of security.
   - Arises from observations, audits and other occurrences from which significant improvement or efficiency can be derived.

   ESLMS will also have an additional section for recording learning from good practice.

4. Some of these assessments could be subjective. All lessons must be carefully considered against these criteria on a case-by-case basis. Consideration should be given to any wider benefit to the Trust in recording any given lesson on ESLMS, irrespective of whether any of the above criteria have been met. This could include examples of good practice that could be adopted more widely, or lessons deduced from themes or trends that have come to light.

5. ESLMS should not, however, be used at unit level to add lessons directly to the database. Lessons should only be recorded on ESLMS once the issue has been considered by the Lessons Team and escalated to LOSC when necessary.

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APPENDIX E LESSONS CASCADE - METHODS FOR SHARING LESSONS

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Method	Process and Forums	Lead
Push communications	Use of E-Mails, briefing, Induction checklists, Safety Learning Alerts, targeted newsletter, training, Local Lessons Log (L3) and EPUT Safety and Lessons Management System (ESLMS). Learning Collaborative Partnership (LCP) Group, Quality and Safety Champions, Quality and Safety Meetings, Safety and Learning Command Call (SALC Call).	EPUT Lessons Team and Deputy Directors of Quality and Safety meeting (DDQS)
Pull communication	Changes, amendment or new policy, protocol or standard operating procedure. SoP / Policy at a Glance	Corporate Nursing and Risk and Compliance Team
Learning Matters: Your Monthly Insight and Reflective Learning	These are the monthly learning lessons forum with wider representation and input from the Subject Matter Experts in the learning collaborative local network	Coordinator and Lead – Lessons Team, Medical Leads Others – Patient Experience and other specialist areas
Themed directorate quarterly learning live events	Each directorate to identify key learning to be cascaded via a live event on a quarterly basis (source of learning could be local, regional or national)	Operational Director Deputy Medical Director Deputy Director of Quality and Safety
Triangulated lessons quarterly report	A report from triangulated lessons across different services will be provided to the Learning Oversight Sub-Committee and Quality and Safety Committee on a quarterly basis. To include learning from deaths review.	Lessons Analysts, Head of PSIM, Learning from Death Lead, Safeguarding Lead, Patient Safety Specialist, Head of Complaints and Head of Legal
Bi-annual thematic reviews of PSIs	There will be thematic reviews of PSIs reported by the Trust, with the findings and learning to be shared with the relevant senior leaders and stakeholders	Head of Patient Safety Incident Management
Quarterly meetings with other providers to share learning/agree actions for joint systems and joint investigations	East of England Integrated Care Boards and other multi-agencies	Functional Lessons Analyst /Head of Shared Learning / Patient Safety Specialist and Head of PSIM
Online network	Culture of Learning Icon on desktop, Safety & Learning portal on Intranet	Digital and Communications Team

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APPENDIX F GUIDANCE FOR ANALYSIS BASED ON WORK SYSTEM ELEMENTS (SEIPS)

WORK SYSTEM ELEMENTS AND PERFORMANCE INFLUENCING FACTORS

TOOLS & TECHNOLOGY

Characteristics such as:

- Usability
- Accessibility
- Familiarity
- Level of automation
- Portability and functionality
- Maintenance (outdated, malfunctioning)
- How are they used?
- Share your insights into equipment availability & appropriateness
- Is equipment reliable
- How is information is presented (e.g. records/IT systems)
- Are alarms and/or alerts - useful/functioning?
- Equipment positioning. Is this optimal?
- Are manuals/procedures/supports accessible?
- Do you have to adapt the tools?

TASKS

- Specific actions within larger work processes
- Includes task attributes such as:
- Difficulty
- Complexity
- Variety
- Ambiguity
- Sequence

Think about/discuss

- The task demands staff face
- Tasks which are complex or challenging to carry out
- Staff experiences of the workload Are there time pressures? if yes, please explore
- Does task repetition/ monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

PERSON

individual characteristics:

- Psychological impacts (e.g., frustration, stress, burnout)
- Cognitive factors (attention, memory, confusion)
- Preferences, personal goals
- Knowledge, competence, skills
- Physiological factors (illness, dehydration)
- Physical strength and needs

Collective characteristics:

- Team cohesiveness

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APPENDIX F GUIDANCE FOR ANALYSIS BASED ON WORK SYSTEM ELEMENTS (SEIPS)

WORK SYSTEM ELEMENTS AND PERFORMANCE INFLUENCING FACTORS

ORGANISATION

Structures external to a person (but often put in place by people) that organise time, space, resources, and activity.

Within institutions:

- Work schedules/staffing
- Workload assignment
- Management and incentive systems
- Organisational culture (values, commitment, transparency)
- Training
- Policies/procedures
- Resource availability and recruitment

In other settings:

- Communication infrastructure
- Living arrangements
- Family roles and responsibilities
- Work and life schedules
- Financial and health-related resources

INTERNAL ENVIRONMENT

Physical environment such as characteristics of:

- Ambient environment: lighting, noise, vibration, temperature
- Physical layout and available space, lines of sight
- Housekeeping: cluttered, organisation, cleanliness
- Distractions

How does work space support safe patient care/good performance?

EXTERNAL ENVIRONMENT

- Societal, economic, regulatory and policy factors outside an organisation

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APPENDIX F GUIDANCE FOR ANALYSIS BASED ON WORK SYSTEM ELEMENTS (SEIPS)

STRENGTH OF CONTROLS

EXAMPLES OF ACTIONS WHICH MAY BE STRONGER TO WEAKER IN THEIR EFFECTIVENESS TO IMPROVE SAFETY

	Stronger actions (more system-based, require less reliance on humans to remember to perform the task correctly)	**Intermediate strength actions**	**Weaker actions** (more person-focused, require more reliance on humans to remember to perform the task correctly)
EXAMPLES	• Minimise processes that rely on memory • Simplifying a process and remove unnecessary steps • Standardise equipment or process • Engineering controls (Interlock / forcing functions) • Tangible involvement by leadership – cultural approach • Architectural / physical plant changes • New devices with usability testing before purchasing	• Eliminate / reduce distractions • Eliminate look and sound-alikes • Standardise communication tools • Checklists / cognitive aids • Enhance documentation, communication • Software enhancements or modifications • Redundancy (eg changing a simultaneous two-person check to one independent of each other) • Increase staffing / reduce workload • Education using simulation and refreshers sessions & observations	• Double checks • Reminders • Warnings & labels • New procedure, memorandum / policy • Re-training • Additional studies or analysis • Disciplinary action

References:
From Discovery to Design: The Evolution of Human Factors in Healthcare by Joseph A. Cafazzo and Olivier St-Cyr
How to make the most of actions and outcomes by C Lee, K Hirschler.

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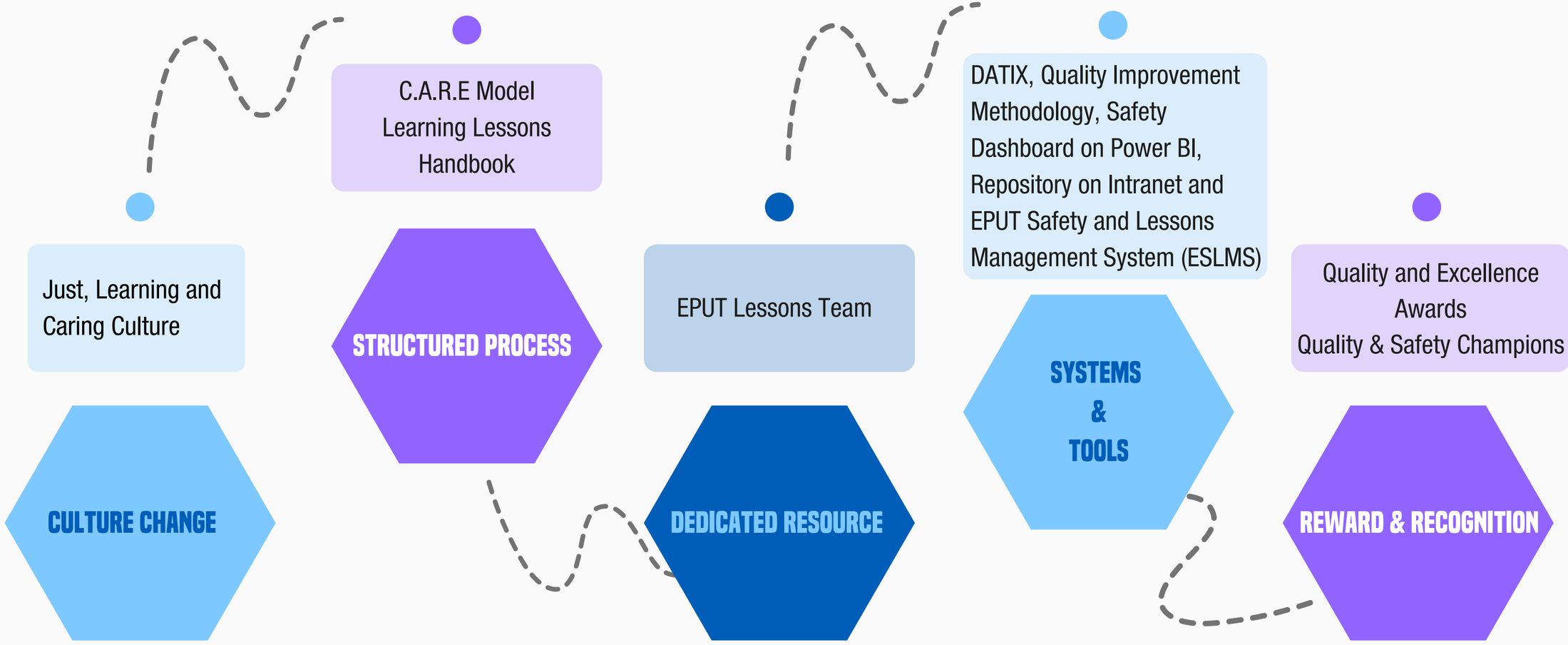
APPENDIX G CONDITIONS FOR SUCCESS OF ECOL



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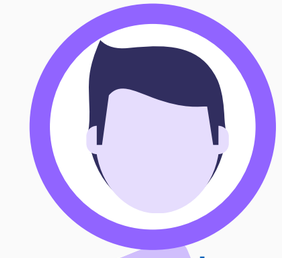
APPENDIX H LESSONS TEAM FUNCTIONS

Functional Lessons Analyst & Head of Shared Learning

Responsible for the day to day operational management of the team and delivery of the key outcomes for the culture of learning ambition in the Trust. Responsible for the oversight and implementation of the methods of cascading lessons. The Head of Shared Learning is the Chair of the Learning Collaborative Partnership (LCP) Group.



Lessons Facilitator

Lead for development of training materials and delivery of training to operational and corporate/support services teams. The Lessons Facilitator will support delivery of Patient Safety Syllabus, MaPSaF Tool, Human Factors Training, Corporate Induction and Learning Lessons Customised Training.

Lessons Analyst

Analysis of information from formal and informal routes; thematic analysis, first and second line assurance testing. The Lessons Analyst is responsible for the oversight of the Safety Dashboard and will instigate the need for a review over set periods and will contribute to deep dives and reviews commissioned to the Lessons Team. The Lessons Analyst will deputise for the Head of Shared Learning in their absence.

LESSONS TEAM

Lessons Team Database Manager

Inputting of technical data, gate keeper for EPUT Lessons Identified Management System ELIMS and support for deep dive into lower level Local Lessons Log (L3) and second line assurance testing. Database Manager will contribute to deep dive reviews commissioned by the Lesson Teams, LOSC and Executive Lead for Safety.

Lessons Team Administrator

To provide a comprehensive secretarial and administrative support to the project manager for EPUT Culture of Learning Work Programme and the Lessons Team, as well as having responsibility for supporting specific project work within both areas.

Lessons Communications Business Partner

This role is essential in sharing important lessons and spreading key information throughout the Trust. With a strong desire to create clear and engaging visual content. The role focuses on making straightforward communication campaigns to pass on vital information and learnings. With their graphic design skills, they ensure that content is clear and easily understood by all.

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APPENDIX I ACKNOWLEDGEMENT

Acknowledgement

We would like to express our gratitude to the Deputy Chief of the General Staff at the Ministry of Defence (MOD) and Brigadier Guy Boxall MBE, Assistance Chief of Staff, Strategic Command Infrastructure. He has been instrumental in supporting us and granting us permission to adopt the Army Learning Lessons principles in creating the EPUT Culture of Learning (ECOL).

A special acknowledgement to our partners at MASS, a Cohort PLC company, for their unwavering contribution, co-operation and co-production in the development of EPUT's Culture of Learning strategy. Their experience and insight gained and shared, having established their own lessons identified-to-learned processes, have been invaluable.

We are thankful to the EPUT Executive Management Team for their constant support, as well as to all of our colleagues, Patient Safety Partners and stakeholders who have played an active role in the development of ECOL.

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APPENDIX J EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment

This procedural document will be applied fairly to all employees regardless of race, ethnicity; colour or nationality, gender, age, disability; sexual orientation; religion or belief, whether full or part-time or employed under a permanent or a fixed-term contract or any other relevant factor. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees.

By committing to a procedural document that encourages equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce and actively seeks to benefit from their differing skills, knowledge, and experiences to provide an exemplary healthcare service. The Trust is committed to promoting equality, diversity and inclusion best practices within the workforce and in other areas where it has influence.

Where there are barriers to understanding, e.g. an employee has difficulty in reading or writing or where English is not their first language or an employee with a disability who requires the document to be presented in a different format, additional support will be put in place with permission from the Equality, Diversity and Inclusion Team wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged.

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APPENDIX K STAKEHOLDER ENGAGEMENT

Stakeholder Engagement

Executive Management Team
EPUT Lessons Team
Patient Safety Partners
Care Unit Leadership Team
Members of the Quality and Safety Group
Members of the Learning Oversight Sub-Committee
Members of the Learning Collaborative Partnership meeting
Members of EPUT Culture of Learning (ECOL) Steering Group
Operational Teams
Corporate Services

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APPENDIX L KEY RESOURCES

Desktop Icon

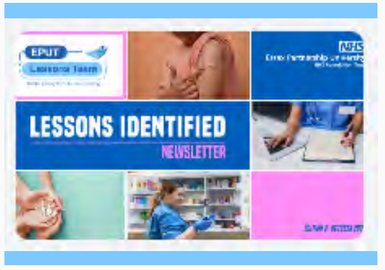
A Culture of Learning desktop icon is available on all Trust computers and laptops. The icon will take staff directly to the EPUT Culture of Learning InPut page where key resources are stored.

Safety Learning Alert

Distributed via Datix to teams where the identified learning is aligned with for immediate notification and action.

Lessons Identified Newsletter

Produced monthly in the Learning Collaborative Partnership (LCP) Group by subject matter experts. The newsletter includes a collection of key learning which has been identified within clinical and corporate support services.



5 Key Messages

Produced monthly in the Learning Collaborative Partnership (LCP) Group by subject matter experts. Short, concise learning details are contained within.

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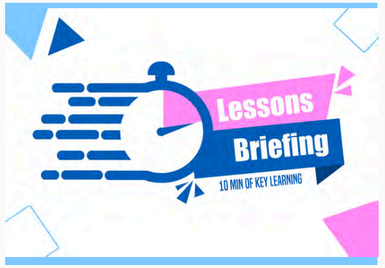
APPENDIX L KEY RESOURCES

Learning Matters

A Trustwide monthly 45 minute live session delivered by the Lessons Team and subject matter experts. Sessions focus on identified learning themes and is an interactive forum on Microsoft Teams.

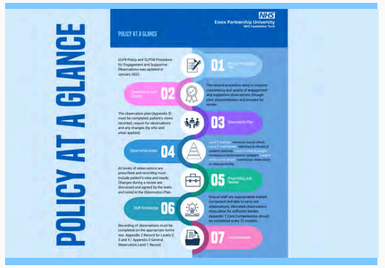
Lessons Briefing

A poster detailing a key learning message for a wide audience across the organisation.



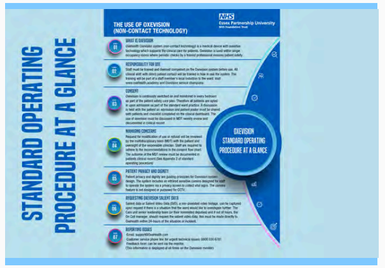
Policy At A Glance

These are generated when there is a requirement to have relevant policy details within a concise format. They should be read and followed alongside the full policy document.



Standard Operating Procedure At A Glance

These are generated when there is a requirement to have relevant procedure details within a concise format. They should be read and followed alongside the full policy and procedure document.



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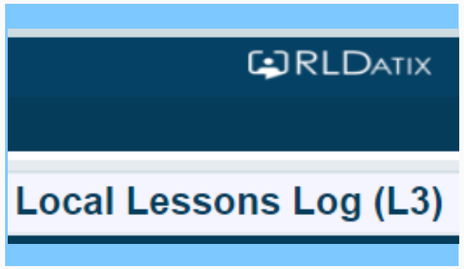
APPENDIX L KEY RESOURCES

Patient Safety Dashboard

The Patient Safety Dashboard provides a visual overview of key safety metrics and indicators within the Trust. It consolidates information in an easily-understandable format, allowing colleagues to effectively analyse safety-related performance. You can request access to the Dashboard via the IT Service Desk. Anyone in the organisation can request access to this report.

Local Lessons Log (L3)

The Local Lessons Log (L3) is the investigation section of the Managers Datix form which asks if any new lessons have been identified from the reported incident.



THANK YOU FOR YOUR ATTENTION