



# Share & Learn: 12 months on

January 2024



## TABLE OF CONTENTS

BACKGROUND .....	3
INTRODUCTION .....	3
REVIEW .....	3
THEMES AND FINDINGS: OVERVIEW .....	4
IMPACT ON THE WIDER INDEPENDENT SECTOR .....	4
IMPACT ON SHARE & LEARN COMMUNITY OF PRACTICE MEMBERS .....	5
VIEWS ON ENABLING FURTHER SPREAD AMONGST THE WIDER SECTOR .....	6
VIEWS ON HOW TO TAKE THE SHARE & LEARN COP FORWARD .....	6
CONCLUSIONS .....	6

## Background

Reporting and learning from incidents is an essential element in patient safety which encourages and supports the development of an open safety culture. Responding appropriately when things have gone wrong in healthcare is a key opportunity for organisations to continually learn and consistently aim to improve the safety of services provided to patients. (Ref: [NHS Patient Safety Strategy July 2019](#))

IHPN members have a strong commitment to patient safety, and so recognised the opportunity to share learning from patient harms and near miss events across the membership to support development of best practice. With agreement from the IHPN Strategic Council, a Share and Learn Community of Practice (CoP) was established and commenced in September 2022. The meetings are held quarterly and a Share & Learn CoP newsletter is circulated across the IHPN membership to share learnings and outcomes.

Member organisations already have robust frameworks, systems in place as part of good clinical governance, for sharing lessons internally from serious incidents, near miss events, significant complaints or when their systems or processes have gone wrong. The purpose of the Share and Learn CoP is not to replace organisations own approach but to enhance the opportunity for learning by enabling members to share their internal events and learning from incidents with other IHPN members.

## Introduction

The IHPN Share & Learn CoP has now been in place for 12 months. The CoP has good engagement from members but we know healthcare in general has challenges when embedding change. The aim was to pause and review, check if it was relevant or if any difference has been made to patient safety across the independent sector or if any changes were required.

Outcomes from the review will provide an assessment of the impact that the Share & Learn CoP has had in the 12 months following its launch as well as to understand how the outcomes from the meetings have been used, its strengths and areas where it can be improved. The review will help IHPN identify where to focus additional improvements within the CoP meetings and sharing of outcomes across the sector as well as helping to inform how the wider sector can further embed learning outcomes into their organisational patient safety and governance processes.

## Review

The review looked at the impact of the Share & Learn CoP within IHPN membership. The first part of the review looked at the impact on patient safety for providers who are not a member of the Share & Learn CoP. A survey was sent to all Clinical Forum contacts. 3 clinical leads from small acute independent providers responded to the survey.

The second part of the review looked at the impact on providers who are part of the Share & Learn CoP. Interviews with CoP members from 8 organisations that attend the Share & Learn CoP meetings were undertaken to review the extent to which the CoP has had an impact on patient safety. Organisations interviewed include a cross section of larger and smaller acute and primary care providers.

Data and feedback from the reviews were then collated to form an overall assessment of impact of the Share & Learn CoP on patient safety within the independent sector and to identify areas of improvement for the future.

## Themes and findings overview

- More work to be done to improve the detail within the Share & Learn newsletter and to distribute to wider teams within organisations.
- There are high levels of engagement with the Share & Learn CoP members and there is an appetite to continue the meetings.
- Amongst CoP members there appears to be a high level of engagement in relation to the Share & Learn CoP. CoP members stated they found the opportunity to meet face to face valuable, it helped to increase confidence they are 'doing the right thing', is a key contributor towards PSIRF, Quality Improvement and Patient Safety delivery and an opportunity to stay up to date with the patient safety agenda.
- More work to be done to improve the awareness of the CoP amongst the wider sector.

From the feedback received it was felt that more work was needed to raise awareness of the Share & Learn CoP across the wider sector. The benefits and contribution to patient safety is not fully recognised by the sector and additional work is required to make access to CoP outcomes and resources made available as a result of the CoP more readily available and easily accessible.

In addition, more work was needed to improve the content of the Share & Learn newsletters. Examples provided included emphasising relevance and ensuring areas of work are highlighted (eg. Infection Prevention & Control, Theatre, Radiology, Clinical Governance etc). In addition, it is felt that the incident summary does not give enough detail in relation to the incident itself. Additional detail would make it more relevant to end users.

## Impact on the wider independent sector

All providers surveyed were aware of the Share & Learn CoP. All said that their organisations were aware of the Share & Learn newsletters that are distributed quarterly. 2 of the 3 providers stated that they do share the newsletters with relevant staff within their organisation and that looking forward, the Share & Learn CoP newsletter will continue to be used to support shared learning and patient safety within their organisation. 1 provider suggested a standardised approach to the presentation of the newsletter would be a good starting point.

Providers were asked to identify any benefits for their organisations as a result of the Share & Learn CoP outcomes. Examples of benefits given include:

*"As a small organisation with two specialist secondary care facilities it allows us to have a more broad insight into events at other sites and that we can then use the lessons learnt in our own facilities."*

*"I have more understanding and awareness."*

Providers were asked to identify whether anything had changed in their organisations as a result of the Share & Learn CoP outcomes. Examples of changes provided include:

*"We add the CoP outcomes to our quarterly clinical governance meetings for discussion."*

*"We shared information about this Group with our local ICB which was received very positively."*

*"We share the outcomes with our local quality group."*

## Impact on the Share & Learn CoP members

Engagement with CoP members is high with all providers stating they find the CoP valuable and beneficial. Networking was stated as the biggest benefit to the meetings and the ability to learn from each other in a safe environment was noted by all members of the CoP. However, despite all members highlighting the benefits of the CoP, only 3 of the 8 providers interviewed cascade the learning outcomes wider throughout their organisation and had taken steps to integrate the learning outcomes within their governance processes.

When asked to identify what had changed in their organisations as a result of the Share & Learn CoP, one provider indicated that they have implemented a 72-hour reporting system to improve the reporting and review of incidents, another mentioned their biggest learning was supporting family members during a serious incident and then having the ability to share learnings across the sector via the Share & Learn CoP. Another provider added that the CoP meeting outcomes once summarised and shared are taken via the organisation's corporate governance structure to cascade learnings across the organisation and within individual hospitals. The same provider has utilised one of the resources shared amongst the members within the CoP to improve their review and reporting process for infections which has proved a benefit to the organisation.

We have also seen CoP outcomes being embedded into Clinical Governance structures and added as a standing agenda item at Clinical Governance meetings, used during discussions with ICBs, provided as part of feedback in relation to patient complaints and also during discussion with regulatory bodies. In many cases, smaller organisations indicated that they have less of a challenge when it comes to embedding the outcomes within their organisations Clinical Governance structures as they feel it is easier to cascade learning due to being on a smaller scale.

More examples of benefits quoted include:

*"Feel these meetings are so beneficial and looking to adopt a similar case study review within my organisation going forwards"*

*"A number of acute providers have developed a small sub-group as an off shoot from the CoP which is independent of IHPN for providers to discuss additional patient safety topics and to provide peer support which they have said has proved invaluable especially for smaller providers"*

*"Held DMA calls with CQC and the Share & Learn CoP went down well with them. It is essentially satisfying the CQC requirement. Community and benchmarking were the 2 areas where CQC felt Share & Learn hits the mark"*

All providers interviewed felt there was more they could be doing to embed the CoP outcomes into their Clinical Governance processes and plan to action this going forwards. A provider suggested that at the start of each meeting, providers could feedback to the group what action if any has been taken to address the learning outcomes from the previous meeting and actions captured in an action log, placing more ownership back on the providers. In addition, another suggestion was to ask CoP members what actions they may be taking in response to the learning outcomes prior to closing the meeting and capture the actions within in the newsletters and share sector wide.

## Views on enabling further spread amongst the wider sector

Some interviewees felt that there was work to be done to make the shared learning outcomes newsletter as user friendly as possible. A standardised approach is required and clarity on who and what department the newsletters are to be shared with.

In addition, the incident summary requires more detail in relation to the incident making it more relevant to end users. Another suggestion was made to consider inviting CoP members to present at the Clinical Forum to share the aims of the CoP and also to walk through the newsletters and share some of the benefits of the shared learnings to raise awareness and to increase engagement of the wider sector.

Continuing to raise awareness about the Share & Learn CoP will be a crucial part of learning from patient safety incidents across the independent sector and a key element to embedding the learning outcomes.

## Views on how to take the Share & Learn CoP forward

The views of the members are that they wish to continue the Share & Learn CoP. Increasing the profile of the Share & Learn CoP will be vital to taking this forward in order to include more members in its work.

Explore the possibility of moving to hosting 2 meetings virtually and 2 meetings in person which may increase attendance as some providers struggle to attend all of the face-to-face meetings. However, members felt the in-person meetings are more relatable and intimate than those held on teams. Others state that in person meetings allows for more open discussion whereas it does not flow as naturally when on teams.

A request will be made to providers to host the CoP meetings within their organisation which will provide a great opportunity for providers to visit and view other organisations.

Members found the attendance of a Human Factors expert during the meetings to be valuable as it adds a useful systems-thinking dimension when working through the patient safety incident during the meeting.

The development of the IHPN Share & Learn webpage with a repository function with access for CoP members and the wider sector will also increase the profile and reach of the CoP.

Produce an annual summary report to consolidate shared learnings and outcomes to be distributed to all members and shared by IHPN via teams.

## Conclusions

Since the start of the Share & Learn CoP, the biggest impact has clearly been on the members of the CoP rather than the wider IHPN membership. There is evidence of some smaller providers who have embedded the learning outcomes into their governance processes but this is yet to be realised in some of the larger providers and the wider sector organisations.

The CoP has enabled a small number of organisations to review and update practice with a view to improving patient safety. Importantly, there is also an appetite for continuation of the S&L CoP within the sector. This further use and development will help to encourage providers not involved to engage and embed the shared learnings.

The ability to share learning across organisations and the independent sector demonstrates a high regard for patient safety to patients, regulators and stakeholders more widely. The next year needs to see

independent providers, regardless of size, embed the shared learning outcomes into their continuous quality improvement programmes and monitor its impact. Raising the profile of the CoP will be paramount and initiatives such as inviting members to speak at IHPN forums will be considered.

Opening up the offer to the wider sector without losing the group dynamic and safe environment will be crucial in improving engagement with the CoP.

Improving the way in which we communicate by exploring available digital systems that can present the outcomes of the meetings in a more user friendly format. The development of the IHPN Share & Learn page will also support this improvement.

Meetings to remain in person and the potential to move to a mix of virtual and in person meetings to be explored later in the year.

Each organisation that has contributed to this document have voiced their commitment and desire to continue to share and learn from patient safety incidents across the sector. The cascade of learnings has been made possible by providers' willingness to be open and reflective both with themselves and other organisations in the independent sector, sharing what has been put in place to improve patient safety within their hospital, between hospitals that are part of a corporate group and sometimes their local trusts and regulatory bodies. Learning from others and sharing best practice is vital and through the IHPN Share & Learn Community of Practice and through ongoing membership engagement, together we can continue to turn the dial on patient safety.