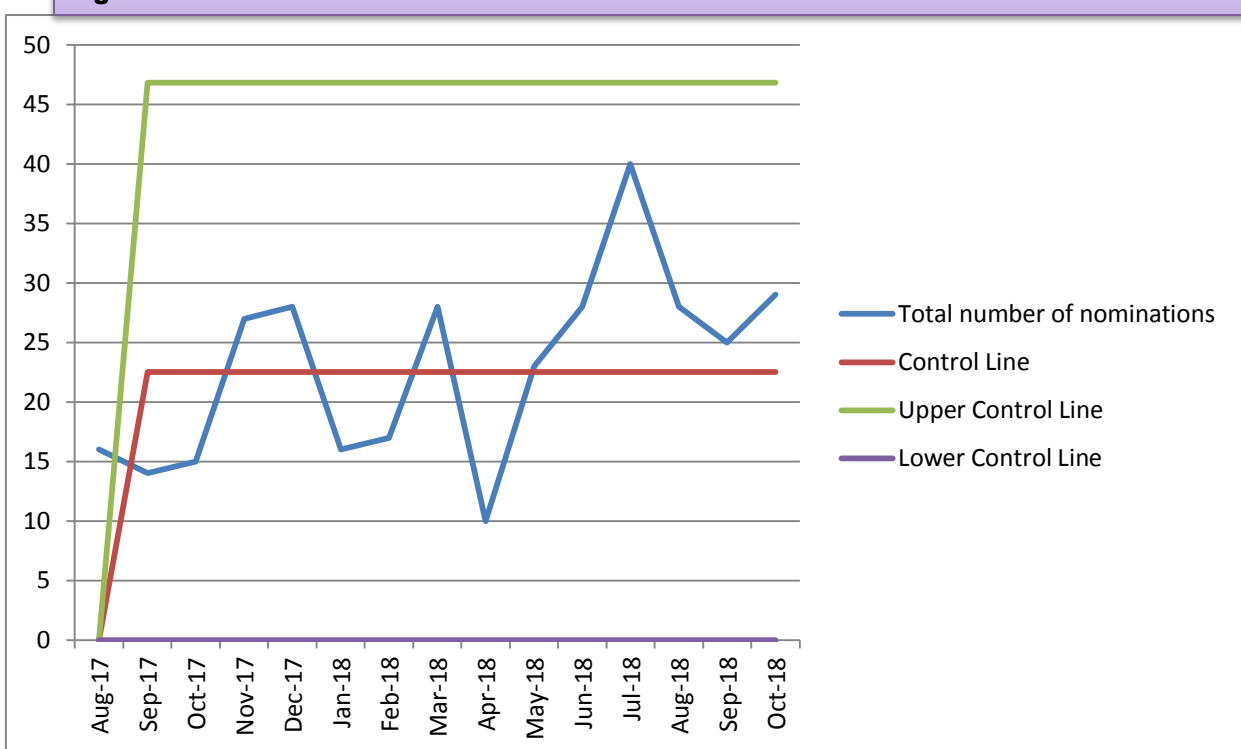
RIGHT CAUSE ANALYSIS- INTEGRATING AI INTO LFE LEARNING

Walsall Healthcare NHS Trust has been promoting learning from excellence and appreciative inquiry since August 2017. This has been pioneered by the Patient Safety Team where we identified the pilot areas to test Learning from Excellence- Paediatrics, A&E, Community and General Surgery. After successful piloting in these 4 areas, LFE has been rolled out across the organisation. Use of the existing reporting tool brings familiarity to the organisation and ease of access. Staff feedback has been positive with good engagement with changing the culture and learning from things going right.



The graph is a positive indicator of the long term future of learning from excellence. November/December being the busiest time for the Trust still had a large number of nominations recorded. Nominations are on the increase again!

learning from excellence

Easy Nominating Process

Same process as incident reporting

- **Please describe what happened (this is linked to the Trust values, which staff have to pick the most relevant one)**
- **What did you consider excellent?**
- **What was the outcome?**
- **What can we learn/do differently to share good practice?**

The main focus of learning from excellence is to help share good practice and improve working practices across the Trust.

Grading and Explanation

All excellence nominations are reviewed at a monthly LFE Steering group where the grades are agreed for each nomination and agree who will review the A's and B's. This meeting uses an MDT approach which includes Consultants, Matrons and governance representatives.

Grade A – receive an LfE letter, including detailing that they will be put forward for the 'Learning from Excellence' category at the Annual Excellence Awards, while also still receiving a Colleague Recognition Scheme card and badge. A full Right Cause Analysis will be undertaking to ensure that the learning from the event is fully investigated using the same tools as a Root Cause Analysis. There will be a series of actions developed from the review which will be supported by the governance team

Grade B – receive an LfE letter and a Colleague Recognition Scheme card and badge + invitation to undertake a local, concise review to capture the learning for sharing

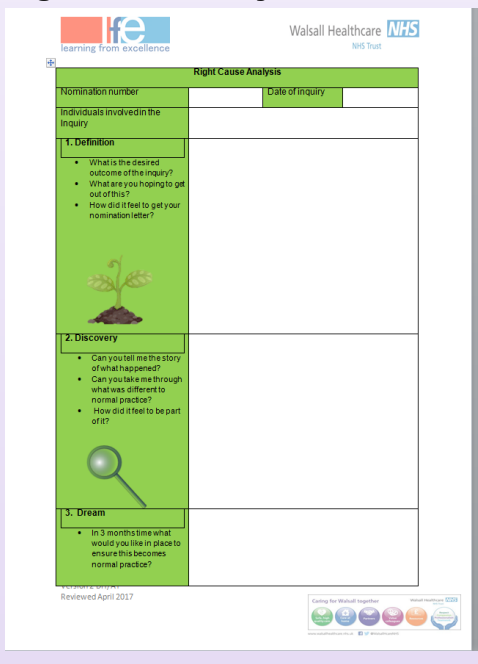
Grade C – receive an LfE letter to acknowledge their nomination and the hard work that they are doing.

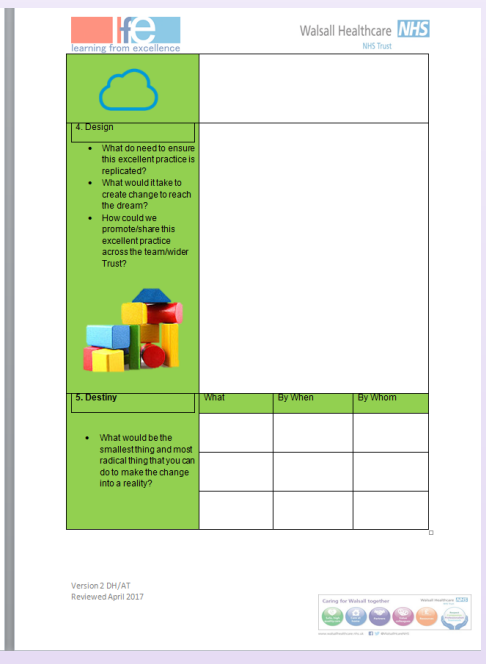
And going forward……

The Patient Safety Team continues to embed and promote LfE. The team have developed glances from a Learning From Excellence review for either a B or an A to share in poster form everything that has been discovered from the RCA/concise inquiry and what people can learn from these nominations.

We will continue to undertake RCA's into all A's and support the Divisions/Care Groups to embark on more concise inquiries into B's. The Patient Safety team will support the action implementation from the nominations to ensure learning is shared and changes can be made quickly to support the replication of positive change.

Right Cause Analysis





Grade A nominations use tools from Root Cause Analysis to develop ways in which to share good practice and improve other services across the Trust.

Grade B nominations have a local level review that is shorter however still focuses on sharing learning and helping to improve services. We use the 5D model building on already nominated good practice. The 5D model is:

- **Definition- What is the desired outcome of the inquiry? What are you hoping to get out of this? How did it feel to get your nomination letter?**
- **Discovery- Can you tell the story of what happened? Can you take me through what was different to normal practice? How did it feel to be part of it?**
- **Dream- In 3 months' time what would you like in place to ensure this becomes normal practice?**
- **Design- What do we need to ensure this excellence practice is replicated? What would it take to create change to reach the dream? How could we promote/share this excellence practice across the team/wider Trust?**
- **Destiny- What would be the smallest thing and most radical thing that you can do to make the change into a reality?**

Right Cause Analysis outcomes are shared at weekly safety huddles, care groups, at Divisional level and in our lessons learned bulletin as well in our "Glance of a Learning From Excellence". These glances are a one page poster which shares the highlights from the review in a bitesize easy to read document at ward level.