Systems for learning

Maternity and Children Quality Improvement Collaborative (MCQIC) Safety Culture Webinar Series

The Scottish Patient Safety Programme (SPSP) is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm. SPSP supports improvements in safety across a wide range of care settings including maternity, neonatal and paediatric services.

The MCQIC focuses on improving outcomes for babies, children, mothers and families. We work collaboratively with the maternity, neonatal and paediatric units within 14 NHS boards across Scotland to help deliver safe care through quality improvement methodology.

The Essentials of Safe Care (EoSC) are a key element of the SPSP's work. This is a practical package of evidence-based guidance and support that enables Scotland's health and social care system to deliver safe care. It aims to accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

Our driver diagram outlines key elements that support our aim of delivering safe care to every person, within every setting, every time.

In spring 2022 MCQIC held a series of webinars focusing on the EoSC primary driver of **leadership** to promote a **culture of safety at all levels**. This summary provides an overview of the webinar focusing on **systems for learning**. A recording of this webinar can be accessed on our website.

Essentials of Safe Care: Driver Diagram

Aim	Primary drivers	Secondary drivers
To enable the delivery of Safe Care for every person within every system every time	Person centred systems and behaviours are embedded and support safety for everyone	Structures and process that enable safe, person centred care Inclusion and involvement Workforce capacity and capability
	Safe communications within and between teams	Skills: appropriate language, format and content Practice: use of standardised tools for communications Critical Situations: management of communications in different situations
	Leadership to promote a culture of safety at all levels	**Psychological safety** **Staff wellbeing** **Systems for learning**
	Safe consistent clinical and care processes across health and social care settings	Reliable implementation of standard infection prevention and control precautions Safe staffing

Introduction to the Quality Management System

Michael Canavan, Quality Management System Portfolio Lead, Healthcare Improvement Scotland

In his presentation, Michael Canavan gave an overview of learning systems and shared good practice points for those planning or facilitating a learning system.

The Scottish Quality Management System framework supports health and social care organisations to apply a coordinated, and consistent approach to the management of high quality health and care services[1]. A central component of a quality management system is a learning system.

What is a learning system?

> ***"A learning system enables a group of people to come together to share and learn about a particular topic, to build knowledge and accelerate improvements in outcome.***
>
> ***A learning system should:***
>
> - ***support individuals to learn through its culture and networks***
> - ***be informed by evaluation and reflective practice***
> - ***enable people to assess what is and isn't working through the use of qualitative and quantitate data, stories and insights***
> - ***develop processes to aid decision making and turning knowledge in action, and***
> - ***build systems to identify "bright spots" and generalisable learning."***

The Celtic knot illustrates the dynamic nature of a learning system. The diagram shows that a learning system involves gathering insights, making sense of the insights and putting this into action. It also demonstrates that networks are a central component to the learning system, and involved in each activity[2].

Figure 1: An overview of the Scottish Quality Management System.

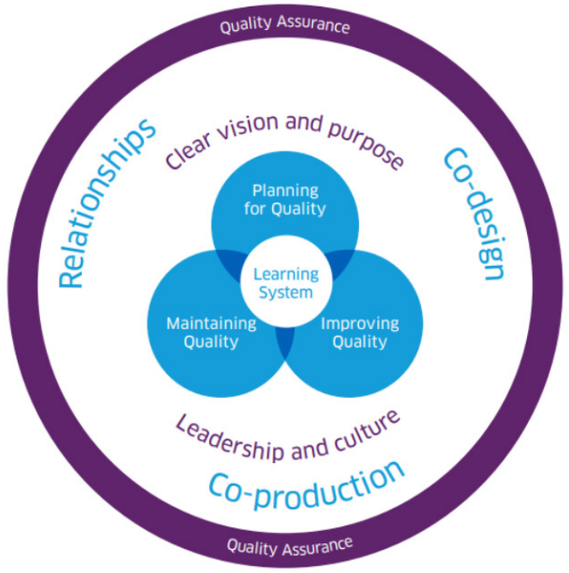
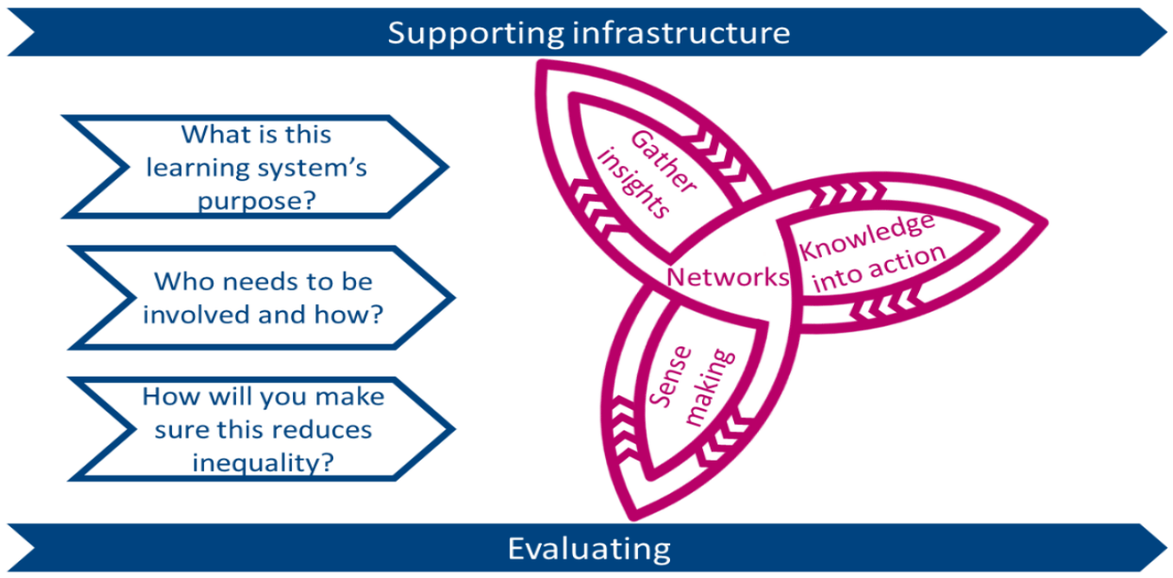


Figure 2: An overview of the dynamic nature of a learning system.



Introduction to the Quality Management System

Practical considerations

Below are some points to consider when establishing a learning system.

Scoping	• What is the purpose of the learning system? • Who needs to be involved and how? • How will you make sure this reduces inequality?
Supporting	• Plan activities, timeline and budgets. • Assess readiness and workforce support required. • Connect to organisational/ national priorities. • Make it easy to participate. • Develop tools and documentation.
Evaluation	• Collect evidence of impact. • Promote self-reflection and flexibility in practice. • Share findings and experience. • Assess achievement on aim and effect on inequalities.

Learning systems are a key component of many improvement programmes within Healthcare Improvement Scotland. Key enablers from Healthcare Improvement Scotland's experience are listed below.

- **Ensure leaders engage** with the network - this may include hosting activities specifically targeted at leaders.
- Provide **regular communications** to networks.
- Organise **webinars led by those delivering the work** locally.
- Provide network members a **variety of ways to participate** (flexibility).
- Ensure **a focus on learning** within network activities.
- Ensure the learning system is **supported by administrative and project staff**.
- Ensure the network have opportunities for **interactive communication.**
- Allow the **audience to suggest topics** for discussion to suit their needs.
- Ensure the learning system is **inclusive** and can be accessed all over Scotland.
- **Plan** and facilitate events and activities well.
- Provide **succinct and clear information**, stories and data.

For more information on learning systems as part of Quality Management Systems, visit the guidance produced by the team on their website.
We would welcome feedback on their learning system definition to inform future editions of this work.

Applying a learning system approach to the Perinatal Mortality Review Tool (PMRT) process.

Emma Campbell, Senior Charge Midwife, NHS Lothian

Senior Charge Midwife Emma Campbell shares NHS Lothian's experience using a learning system approach as part of their process for PMRTs.

The PMRT process supports the review of circumstances and care leading up to, and surrounding each stillbirth and neonatal death. NHS Lothian began using the PMRT in 2019. In 2021, 58 stillbirths and neonatal deaths met the criteria for the PMRT process.

It is important to share high-quality learning from the PMRT reports with stakeholders.

In NHS Lothian, the report is shared with the stakeholders listed below first.

- The report is shared with **the team** completing the review and other l**ead professionals** who were notified during this process. This includes service leads and the clinical management team.
- The report is shared with a **key contact.**
- The report is shared with the **family**. Once they have had the opportunity to read the report, they can meet with a clinical professional to discuss this.

Secondly, points of learning from the reports are considered and shared in a number of ways.

- The **safety brief** is an effective method to share a short, sharp learning action relevant across the service.
- A **newsletter** is issued every 2-3 months which focuses on a particular theme and shares learning specifically related to this.
- Some reports will raise points requiring further action. The **clinical governance** team are informed of these actions and are responsible for managing these.
- **T**he quality improvement team provides support to share relevant **data and learning**.

Staff have fed back that they welcomed having access to learning from the PMRT process.

Further developments to the process are planned.

- The report is being adapted to be more suitable for the families receiving it, as it can be quite technical to read.
- Teams are using the safety briefings in different ways. This will be evaluated to ensure the safety briefing can be fully utilised by all teams.
- NHS Lothian is an early adopter of the national bereavement care pathway. This will affect the process for PMRT reviews and a consistent approach to implementing this is being developed.

Further information

The webinar is available to watch in full on Youtube. You can find the webinar in two parts – part one and part two.

View our presentation slides used on the day.

Our reading list accompanies the webinar.

Read more about Essentials of Safe Care on our website.
Case studies on the systems for learning, staff wellbeing and psychological safety series are now available on our website.

Find us on twitter at @mcqicspsp, #spspmcqic and #spsp247

The National Wellbeing Hub provides support to those who work in health and social care.

References

1. Healthcare Improvement Scotland. Quality Management System; Supporting health and care organisations to reliably deliver high quality care [online]. 2022 [cited 2022 Aug 24]; Available from: https://ihub.scot/improvement-programmes/quality-management-system/about-quality-management-system/.
2. Healthcare Improvement Scotland. Quality Management System; The learning system [online]. 2020 [cited 2022 Aug 24]; Available from: https://ihub.scot/improvement-programmes/quality-management-system/.

Further reading

1. Centre for Public Impact. Human Learning Systems: A practical guide for the curious [online]. 2022 [cited 2022 Sep 22]; Available from: https://www.centreforpublicimpact.org/partnering-for-learning/human-learning-systems.

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contactpublicinvolvement@nhs.scot