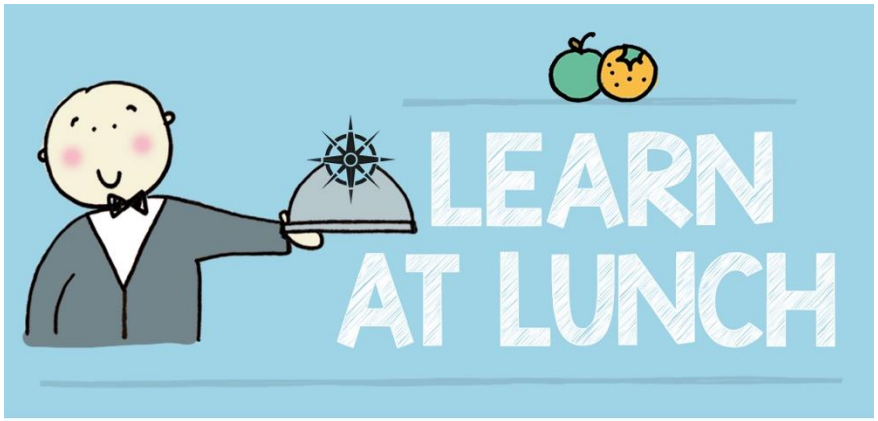
Here's the scoop!
5 September 2024

As summer 2024 comes to a close...

Join us for our after action review learn at lunch

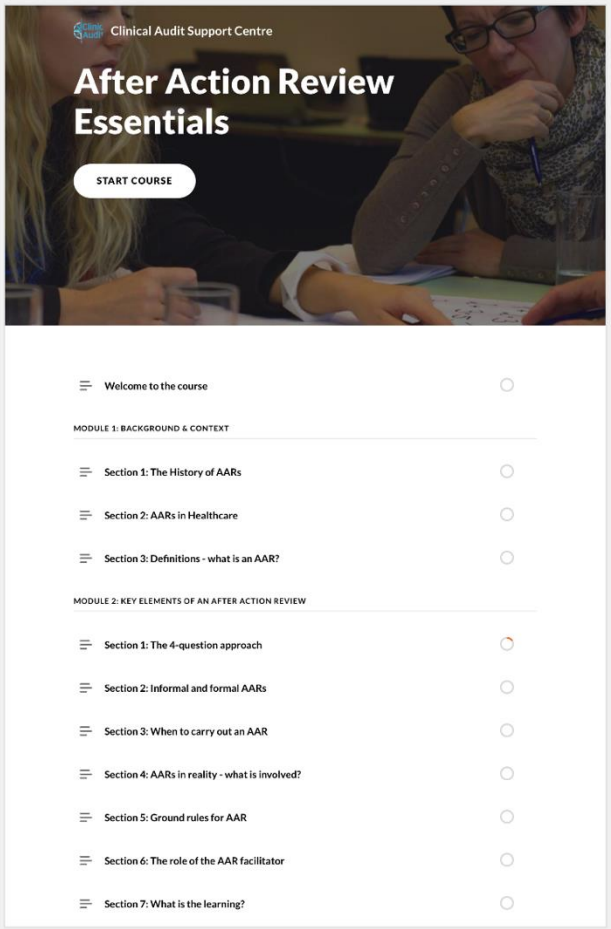
To register your place on the AAR Learn at Lunch session at 12.30 on 05.09.24 simply send your email to: info@clinicalauditsupport.com

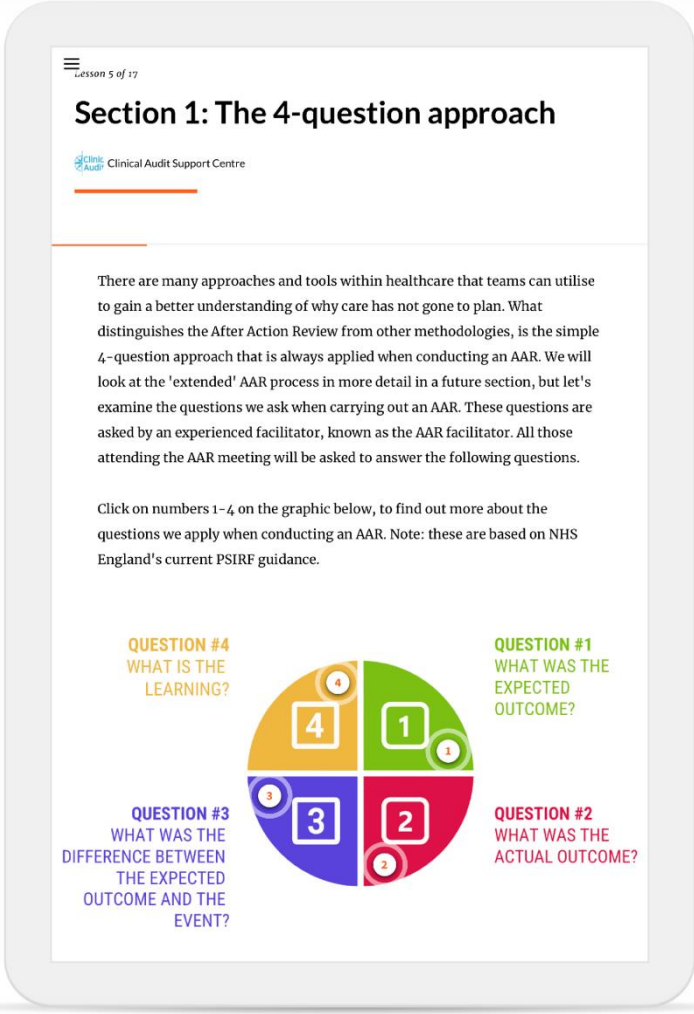
Clinical Audit SUPPORT CENTRE



For more information visit **www.clinicalauditsupport.com**
Follow us on Twitter **@cascleicester**

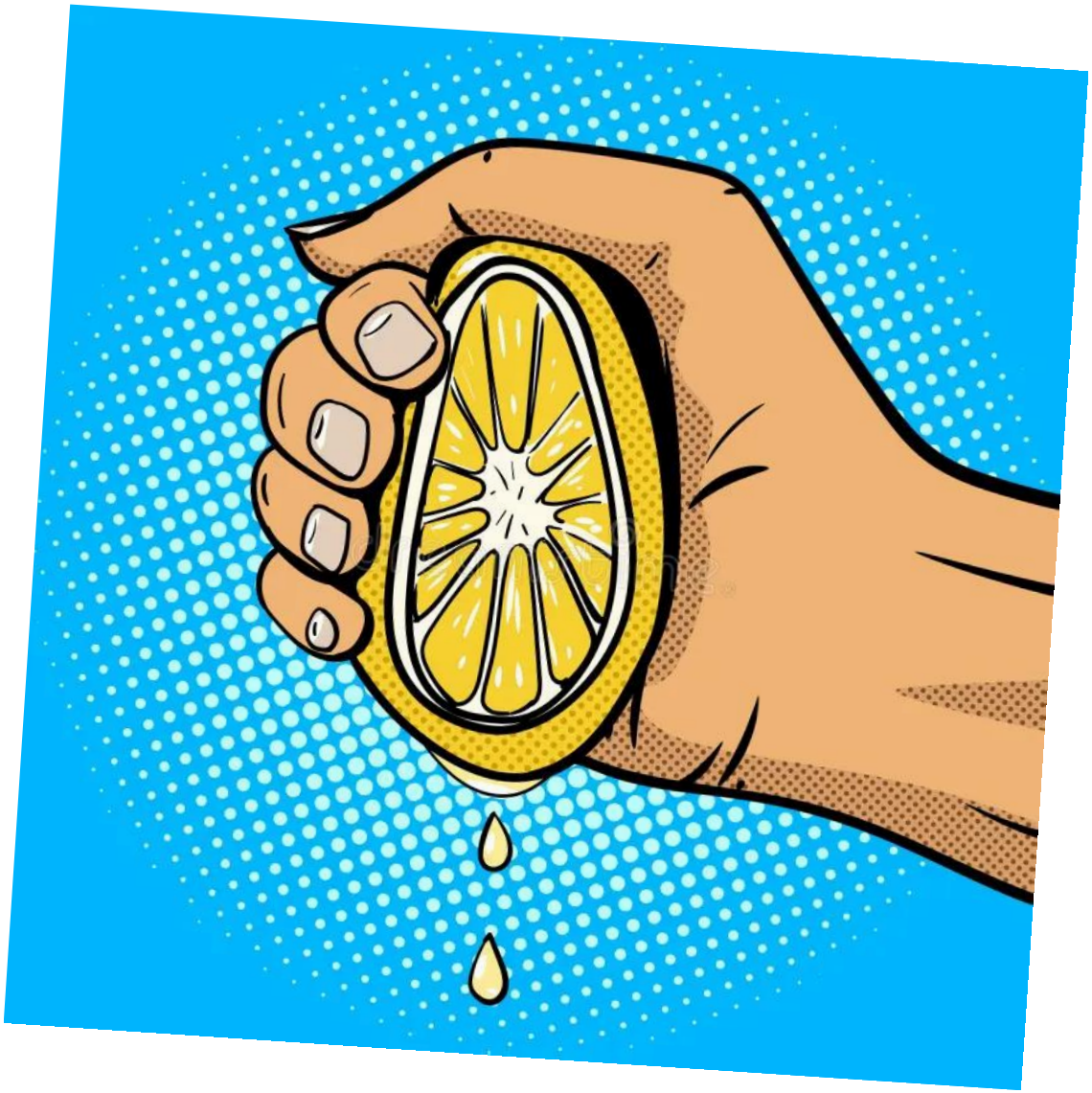
Comprehensive AAR CASC e-learning





Objectives for the session

- Introduce AARs: where have they come from?
- Keep up-to-date with AAR
- The 4-question approach
- AAR in reality: what is involved?
- How could CA and QI teams apply AARs to their work?
- 3 top tips for getting started




60
MIN

Follow-up session in next 6 months…

CASC disclaimer…

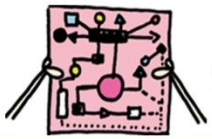
CASC disclaimer…

…there was AAR

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

PSIRF: a new era in patient safety for the NHS and healthcare

DOING THINGS DIFFERENTLY



SYSTEMS THINKING

APPLYING NEW TOOLS AND TECHNIQUES

MAXIMISING LEARNING OPPORTUNITIES

PLANNING & COLLABORATION

@cascleicester

PROPORTIONATE RESPONSE

COMPASSIONATE ENGAGEMENT

ANALYSING TRENDS

LISTENING TO PATIENTS, FAMILIES AND STAFF

SUPPORTIVE OVERSIGHT

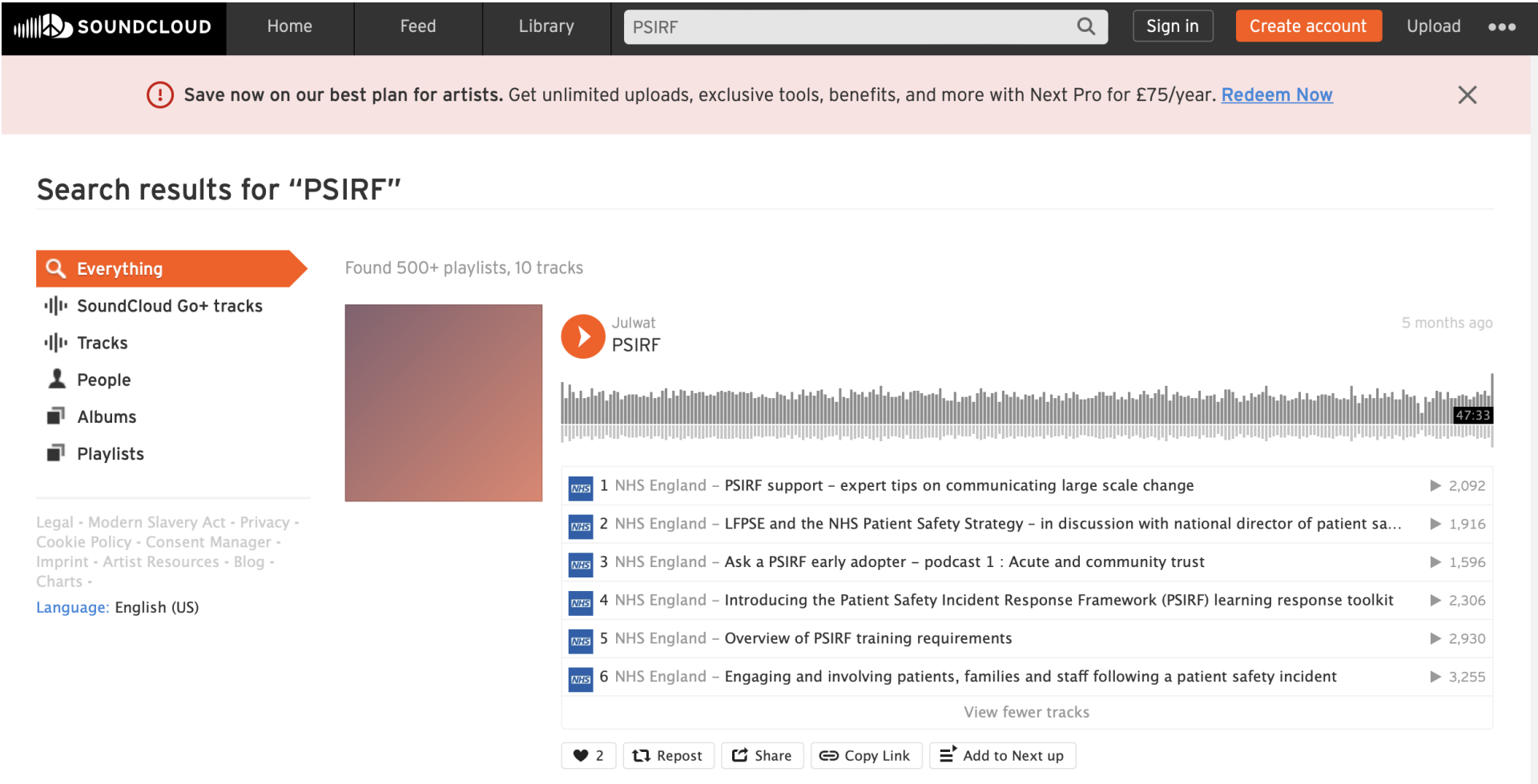
EXPERT INVESTIGATORS

PSYCHOLOGICAL SAFETY

For more information visit www.clinicalauditsupport.com

illustrated by Amy Bradley.

Useful resources: podcasts & twitter



Follow on twitter: @TraceyHerlihey @ptsafetyNHS

FutureNHS Collaboration Platform

NHS England

About us | Our work | Commissioning | Get involved | Insights Platform

PSIRF learning response tools: Introducing a new AAR report template

18 July 2024 12:30pm – 2:00pm BST (+01:00)

Virtual (Microsoft Teams)

ADD TO CALENDAR ORGANISER

PSIRF Discussion Forum

Start a new discussion

TH NEW After Action Review report template and webinar sign up Pinned Broadcast

Dear All,

We're pleased to be able to share a draft AAR report template developed in collaboration with HSSIB, AAR and human factors experts, and provider colleagues.

It's available on FutureNHS within our AAR tool space here: https://future.nhs.uk/NHSps/view?objectId=42826256

We will also be hosting a webinar discussing the template, including some reflections on how it has been used in practice.

The webinar will be online on Thursday 18th July 12:30-3:00pm. You can sign up here: https://www.events.england.nhs.uk/events/psirf-learning-response-tools-introducing-a-new-aar-report-template

Any immediate thoughts/questions etc. please do add to the discussion thread.

Sincerely,

Tracey

Started by Tracey Herlihey 7 days ago.

Read this discussion and 0 replies


HISTORY

Q1: **Which organisation were the first to pioneer the use of AARs?**

- World Health Organisation
- Australian Fire Service
- **US Army**
- Japanese Nuclear Regulation Authority

Q2: **In which decade were AARs commenced in the NHS?**

- 1980s
- 1990s
- 2000s
- **2010s (2008 at UCLH)**

NHS
University College London Hospitals
NHS Foundation Trust

Q3: **How many questions do NHS England recommend are asked when conducting an AAR?**

- 3
- **4**
- 5
- 6

The History of AARs

- Technique first used by US military on missions
  - Timeline is not clear
- Used by many international companies, e.g. BP
- WHO endorse AARs
- Used extensively by Health Service Executive
- Part of NHS England's Learning Response Toolkit
- Referenced regularly at PSIRF events
- Regularly mentioned via Twitter / X
- First used by UCLH in NHS in 2008

AARs are used in many settings!

Nancy Bennett @NancyBEHF · 5d
Minneapolis leaders announce completion of **after-action review** recommendations, unveil new alert system for residents #EmergencyNotification #EmergencyCommunication [Video] Minneapolis Mayor Jacob Frey was joined by city leaders on Tuesday to announce...

From accidentrecoverygiving.com

6

OHSoS @OHSecofState · 3d
Our team took another step in our readiness for November with our **After Action Review** of the March 19 primary election. This gave us the chance to make improvements and maintain best practices in preparation for the November General Election.

1 3 7 673

IAWF @IAWF · 28/03/2024
We are thrilled to welcome Steven Miller, an expert on fire behavior and management, to the 7th International Fire Behavior and Fuels Conference in Tralee, Ireland. He will be delivering a conference synthesis and bringing it all together with an **after-action review**.
#FBF2024

2 6 338

Prabhjot Singh @Singhp... · 25/03/2024
#Grenada has embarked on an **After Action Review** with @pahowho to assess what did & didn't work in its response to COVID-19 pandemic. Multiple stakeholders r meeting this week to discuss, thanks to funding provided by @EU_Commission & in collaboration with @WorldBank @GISGRENADA

4 53

CRSUganda @CRSUgan... · 28/03/2024
As our International Agriculture Education Program ends, we've concluded an **After-Action Review** where teachers from 8 schools developed action plans on how to sustain & expand ag projects in their schools. We thank @USDAForeignAg for supporting this project & ag growth in Uganda!

1 6 144

AARs: gaining momentum in healthcare!

Chris Collison @chris_col... · 15/03/2024
Replying to @RCSI_Irl
Hmmm. This implies that AARs are limited to 'adverse' scenarios? 🤔

Perhaps better to say:

"Adverse healthcare events can be debriefed with **after action reviews** (AARs) where groups discuss: what was expected to happen; what really happened; why; and what can be learnt?"

1 · 217

SWBH- Patient Safety Team @sw... · 3d
That's day 4 of PSIRF done! We completed our first oversight meeting, managed a team (short) walk and coffee, visited one of the wards as part of an **after-action review**, and had a lovely chat about PSIRF with our legal team 😁. #communication #teamwork

1 · 7 · 424

Patient Safety Learning · 09/04/2024
Blog added to the #pslhub - One amazing outcome from an **After Action Review** pslhub.org/learn/improvin... #patientsafety

From pslhub.org

1 · 323

Deborah Dover 💙 @Do... · 26/01/2024
@NHS_ELFT
colleagues hard at work this week, role playing **After Action Reviews** as part of our new AAR conductor training 🎉.

Serious stuff & also really good fun. Massive thanks to @georgechingosho 4 brilliant facilitation.

Dr. Gintare Valentelyte @Gintareva · 4d
New study of the enablers and barriers of **After-Action Review** in an Irish specialist hospital published online.

Read article here:
sciencedirect.com/science/articl...

> **iCAARE** @iCAARE_Study · 4d
> New open-access study from @iCAARE_Study led by @MaireadFinn, provides new research evidence on the enablers and barriers of AAR implementation in an Irish hospital. Lin...

3 · 251

Paul Street @Leadforfalls · 26/02/2024
Visit to Westwood park today. The first ward @BTHFT to show excellent documentation for falls improvement. They now just complete the falls debrief and will be the first ward not to do **after action reviews**. Well done team!! @Jhilty33 @karendawber @Mel_Pickup @willissean

1 · 3 · 17 · 837

AAR appearing more in NHS Jobs searches!

Senior Governance Manager

Save this job

East Kent Hospitals University NHS Foundation Trust
Canterbury CT1 3NG

Salary: **£46,148 to £52,809** a year
Date posted: **23 August 2024**
Closing date: **6 September 2024**

Contract type: **Permanent**
Working pattern: **Full time**

NHS
East Kent Hospitals University
NHS Foundation Trust

NELFT NHS
North East London NHS Foundation Trust

Senior Transformation Project Manager

Save this job

NELFT North East London Foundation Trust
Rainham RM13 8EU

Salary: **£53,755 to £60,504** a year
Date posted: **2 September 2024**
Closing date: **16 September 2024**

Contract type: **Permanent**
Working pattern: **Flexible working, Full time**

NHS England

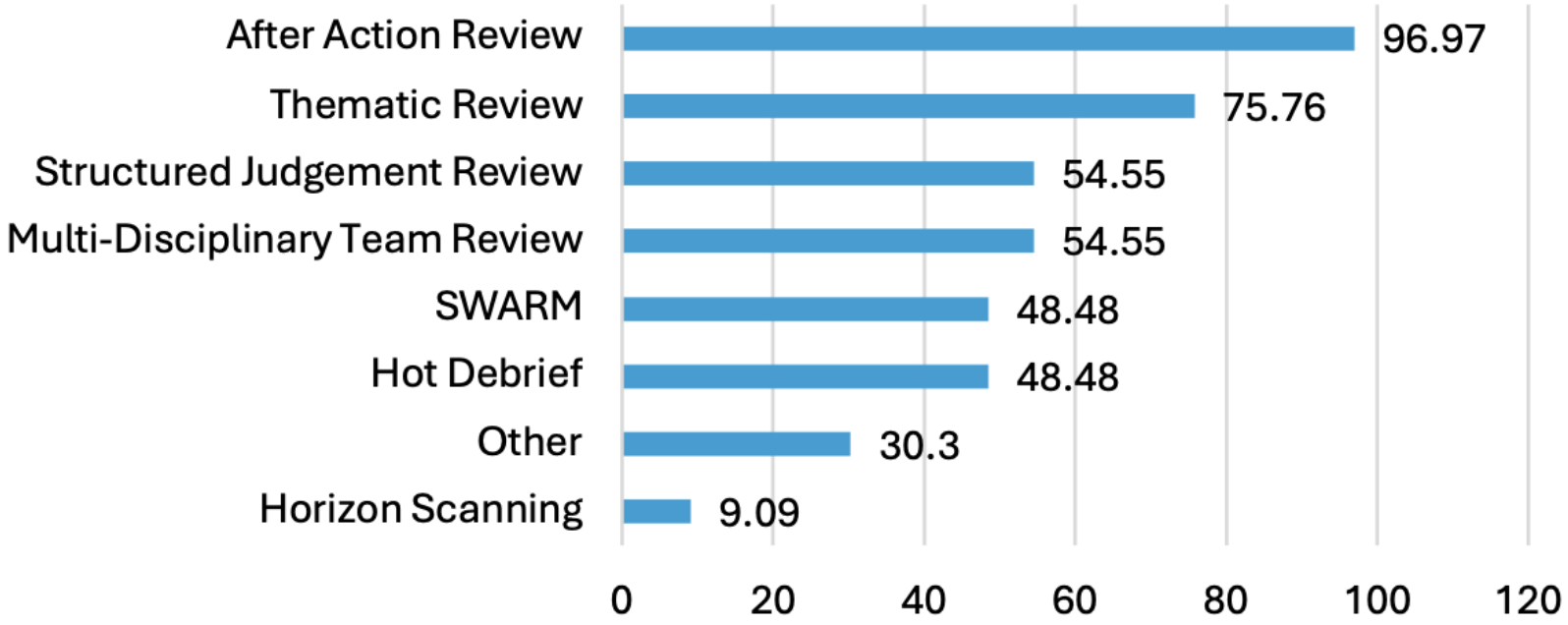
Guide to responding proportionately to patient safety incidents [Sept 2022]

Table 3: National learning response methods

Table 3: National learning response methods

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

Aside from the Patient Safety Incident Investigation (PSII) what Learning Response Tools (LRTs) have been used in your organisation in the past 6 months? (n = 31)



*Judy Walker Associates

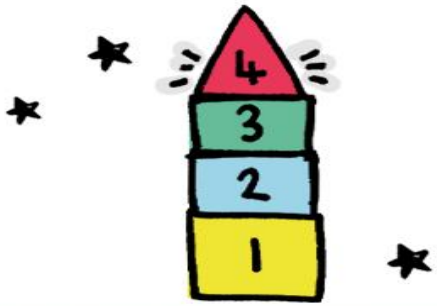
Report available via NHS Futures

What three single words would you use to describe what After Action Reviews mean to you?

Wordcloud Poll | 102 responses | 34 participants

AFTER ACTION REVIEWS

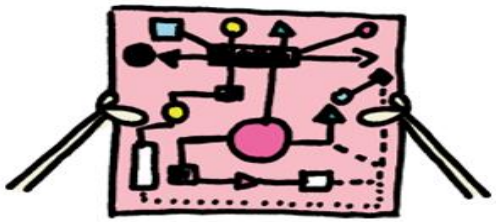
The quest for safer care



SIMPLE AND QUICK TO APPLY

CATCHES LEARNING WHILE IT IS HOT

ALL PARTICIPANTS HAVE A VOICE



EMBRACES SYSTEMS THINKING

LED BY AN INDEPENDENT FACILITATOR

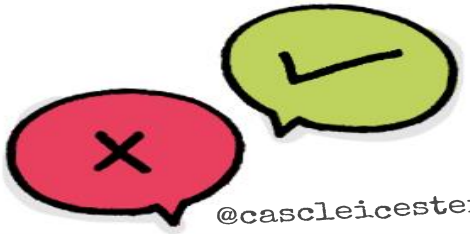
PROMOTES SHARED LEARNING

RPOEMLB

PROBLEM

HELPS SOLVE PROBLEMS

IMPROVES PSYCHOLOGICAL SAFETY



REVIEWS POSITIVE AND NEGATIVE INCIDENTS

"AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents"

NHS England

‘AAR is a structured approach for reflecting on the work of a group or team. By understanding AAR, we methodically capture knowledge about an activity: of what was expected, what really happened, and how it can be improved for better results next time…’

(Artie Mahal, 2018)

The process…

NHS England

After Action Review (AAR)
The quest for improvement...

Clinical Audit SUPPORT CENTRE

QUESTION #4
WHAT IS THE LEARNING?

QUESTION #1
WHAT WAS THE EXPECTED OUTCOME?

QUESTION #3
WHAT WAS THE DIFFERENCE BETWEEN THE EXPECTED OUTCOME AND THE EVENT?

QUESTION #2
WHAT WAS THE ACTUAL OUTCOME?

Source: NHS England Guide to responding proportionately to patient safety incidents
Table 3: National learning response methods (page 13)

Language is important!

1. What was expected to happen?
2. What was the actual outcome?
3. What was the difference between the expected outcome and the event?
4. What is the learning?

NHS England

1. What did we expect to happen?
2. What actually happened?
3. Why was there a difference?
4. What have we learnt?

1. What was planned and expected?
2. What actually happened?
3. What went well and what did not?
4. What can we do better next time?

This is not ideal…

1. What was expected to happen?
2. What was the actual outcome?
3. What was the difference between the expected outcome and the event?
4. What is the learning?

NHS England

*PSIRF Learning Response Toolkit (2022)

1. What was expected?
2. What actually happened?
3. Why was there a difference?
4. What has been learnt?

NHS England

*AAR Summary Template (2024)

After Action Review (AAR)
The quest for improvement...

QUESTION #4
WHAT IS THE LEARNING?

QUESTION #1
WHAT WAS THE EXPECTED OUTCOME?

QUESTION #3
WHAT WAS THE DIFFERENCE BETWEEN THE EXPECTED OUTCOME AND THE EVENT?

QUESTION #2
WHAT WAS THE ACTUAL OUTCOME?

Other questions to consider in stages 2 & 3:
What went well and why?
What will we do the same next time?

The AAR process in reality

1. Determine that an AAR would be beneficial
2. Appoint a facilitator to co-ordinate the meeting
3. Locate a safe space to conduct the meeting
4. Introduce and agree ground rules
5. **Work through the four questions**
   - What was the expected outcome?
6. Write up the findings
7. Share the learning appropriately
   - Need a way to check learning is implemented / effective

National Patient Safety Agency
7 steps for successful SEA

1. Awareness and prioritisation of a significant event
2. Information gathering
3. The facilitated team-based meeting
4. Analysis of the significant event
5. Agree, implement and monitor change
6. Write it up
7. Report, share and review

We could do an AAR today…

1. What was expected to happen?
2. What was the actual outcome?
3. What was the difference between the expected outcome and the event?
4. What is the learning?

NHS England

CASC team could convene at the end of the day to work through the 4 AAR questions, starting with Q1:

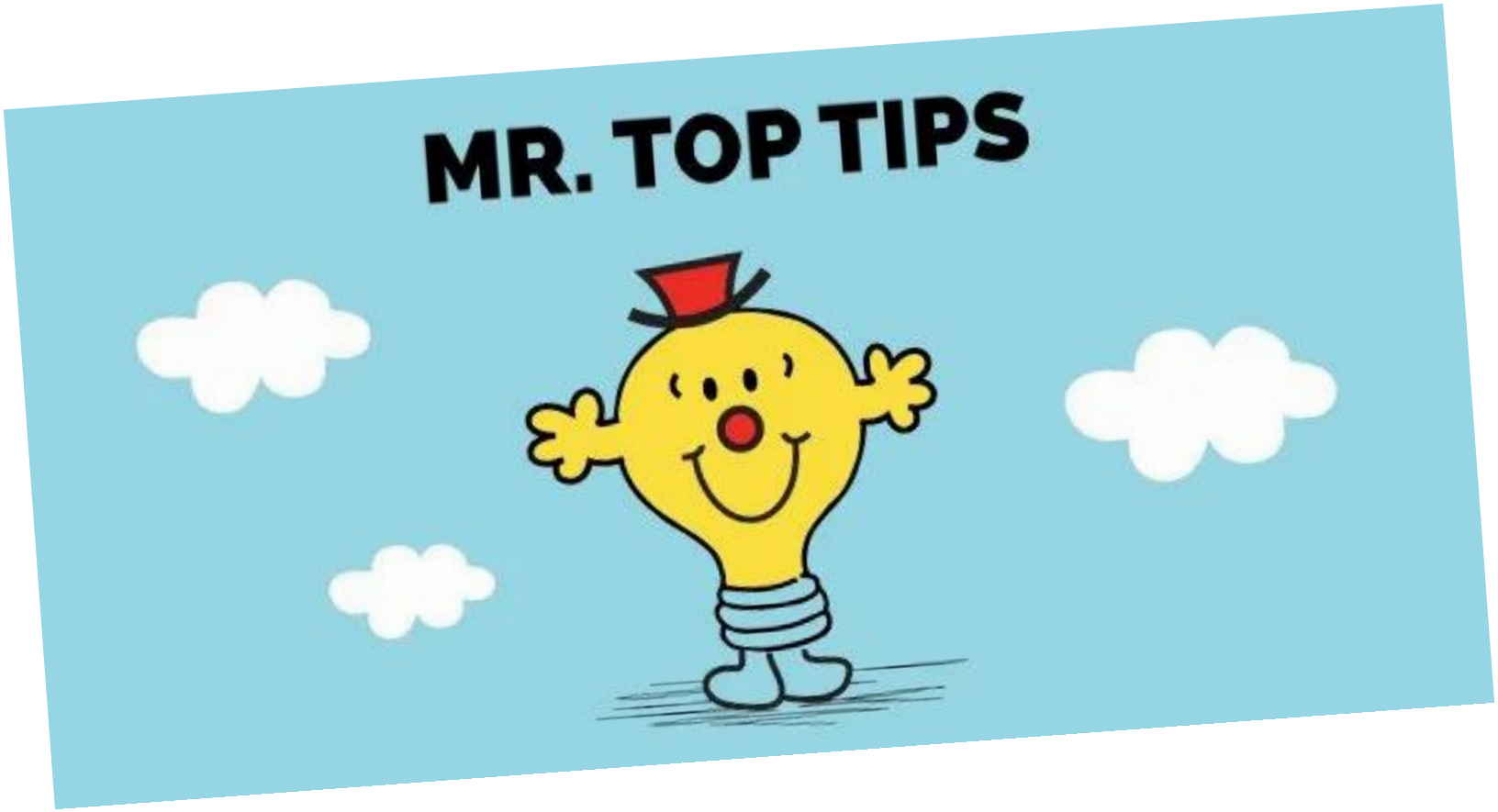
- All objectives and content is covered
- All delegates fully participate / engage
- Evidence of strong interactions and questions
- Questions are answered or picked up via appropriate routes
- No technical issues occur / problems dealt with appropriately
- Learn at Lunch runs to time
- All participants know how to access the slides from the session
- Participants rate the session highly.

Using AARs: in CA and QI

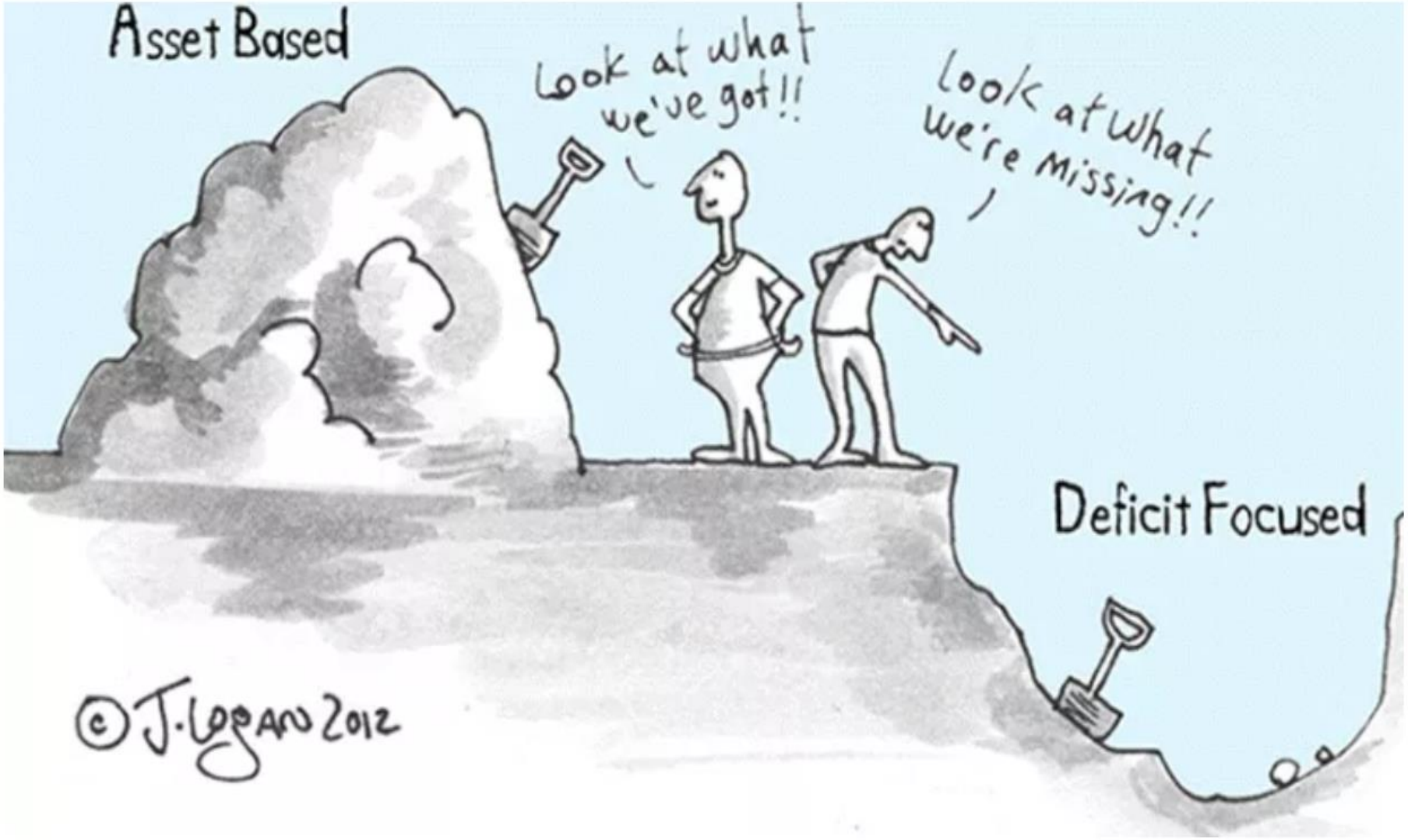
- Review a clinical audit or QI project
- Review engagement in a national clinical audit
- Review an event, e.g. training day, conference, away day
- Review an initiative e.g. engagement in CAAW24
- Review a change in practice:
  - Roll out of AMaT
  - Roll out of a new local clinical audit report template

Why do people like AARs?

Three top tips for getting started:



AAR... is not just about negatives/errors



AFTER ACTION REVIEWS

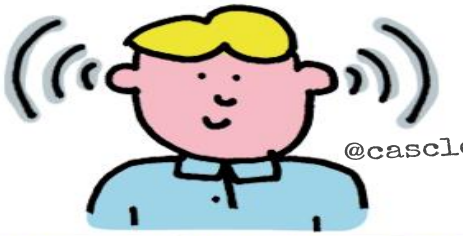
THE GROUND RULES FOR SUCCESS

ATTACK THE PROBLEMS, NOT THE PEOPLE

CONFIDENTIAL PROCESS

TRAINED CONDUCTOR LEADS THE MEETING

START AND FINISH ON TIME



@cascleicester

PARTICIPANTS ACTIVELY LISTEN

NO DISTRACTIONS

LEAVE HIERARCHY AT THE DOOR

For more information visit www.clinicalauditsupport.com

illustrated by Amy Bradley.

What is an After Action Review (AAR)?

An After Action Review (AAR) is a structured, facilitated discussion of an event, which helps the individuals involved:

- Identify what was expected to happen and what actually happened
- Understand why the outcome differed from that which was expected
- Identify what went well and what did not go as well as expected
- Identify learning that can be implemented and shared to inform improvement.

AAR can also be used to review events where there was a positive outcome i.e. to better understand the reasons why a situation went well and whether there was any learning that the team should seek to replicate in the future.

How will AAR help me and my team?

Whatever your role, you come across difficult and challenging moments each and every day. They are often unexpected, for instance, when whatever you planned didn't quite happen the way it was supposed to. How you deal with those moments can often define the way you, your team and service progress and grow.

AAR exists to create a personal and team opportunity to share, understand, learn and ultimately improve outcomes and experiences of care.

What can I expect when I attend an AAR session?

That the AAR is held in a safe environment and is facilitated by a person trained in the conduct of AAR.

That sufficient time has been allocated to enable relevant multidisciplinary involvement.

That ground rules for the conduct of the review are set to enable equal and respectful participation of all attending.

That the meeting will have a clear focus and be structured around the following four questions;

- What did we expect to happen?
- What actually happened?
- Why was there a difference?
- What have we learnt?

What are the benefits of taking part in an AAR?

The team will gain an understanding of:

- the event from the perspective of all involved
- their individual roles in the overall context of the event
- how the system operated at the time of the event
- why the expected outcome was/was not achieved.

AAR will allow the team to ascertain the systems strengths and weaknesses and the learning from the event. AAR will also assist the team in identifying any changes required to support team improvement.

How do I request an AAR?

A request to hold an AAR should be made to your local Quality and Patient Safety Office (or equivalent).

The AAR Facilitator* is critical

*Sometimes referred to as the ‘AAR Conductor’

Classification: Official

Publication approval reference: PAR1465

NHS England

Patient safety incident response standards

Version 1, August 2022

Learning responses are **not** led by staff who were involved in the patient safety incident itself (standard 4.1)

The AAR Facilitator

Worth considering…

Who looks after and supports the AAR conductors?

Signposting

- Slides and other resources will be shared via the CASC website Learn at Lunch webpage landing page
- We will send out a post-event email that links to this a reminder of the evaluation.

THANK YOU!