**Information for patients, families and carers about After Action Review**

Introduction

This leaflet explains about the After Action Review process (often called AAR for short) and how it is being used to improve the care and treatment of patients. It explains what will happen if an AAR is held after something happened to you, a family member or someone you care for, and describes what to expect if you are invited to participate in one.

We cannot always prevent unexpected events or things going wrong, even though we do everything possible to ensure the safety of patients here. It is important that we learn by looking at these events and incidents, identifying what got in the way of the best care and treatment and using that learning to bring about change for the better.

In 2023 NHS England updated its guidance to hospitals and healthcare services on how to improve learning after unexpected events, publishing the Patient Safety Incident Response Framework (<https://www.england.nhs.uk/patient-safety/incident-response-framework/>) and encouraging the use of ‘Learning Response Tools’ to use to ensure learning happens and changes are made to prevent problems being repeated. The After Action Review is one of these Learning Response Tools, which can be used on its own or together with other tools like Patient Safety Incident Investigations.

What is an After Action Review?

An After Action Review (AAR) is a meeting of those directly involved in the ‘action’ which takes place in the days after an event. The AAR is led by a trained ‘AAR Conductor’ who runs the meeting and asks people to answer the following questions:

1. What should have happened?
2. What actually happened?
3. What got in the way of expectations being met?
4. What has been learned and what will be done differently in future?

Research into the use of AAR in healthcare, the military and other safety-critical industries like fire services has shown it to be very effective in improving safety generally and team and individual performance specifically.

Benefits of the AAR approach

1. Improvement happens quicker. Learning and change can take place within days of the event.
2. It increases learning for those who have ‘hands on the patient’. It is the people who were involved in the event who are included in the AAR, so they learn for themselves what needs to change.
3. People from other organisations, such as ambulance services or care homes can be included.
4. The actions and change as a result of the AAR will be decided by those who participate rather than those who manage quality and safety, so the changes are very relevant and can be completed quickly.

How can I be sure that AAR will bring about improvements?

1. In the past, efforts to learn from times when a patient hasn’t received the best care or treatment, have taken a long time to complete and have not usually involved the staff who provide care. To ensure patients get better care in future, changes need to be made by individual staff as well as the teams they work in, and the equipment and processes that they use. The AAR approach means staff can learn what they need to do differently right away and can agree together how to put that into action.
2. The AAR approach is designed to be used frequently, for small as well as bigger ‘actions’. This means that many small changes can be made to prevent bigger problems from arising in future.
3. The lessons learned and changes agreed in AARs are reported to the Quality and Safety Lead so that learning from all AARs is gathered and analysed. This knowledge is used to understand where problems are arising and will guide what will be prioritized to improve patient safety.

What should I expect if an AAR is held to learn from my or my loved one’s care or treatment?

Hospitals and healthcare services have a legal duty to be open and honest with patients, their families or carers when something may have gone wrong and which appears to have caused or could lead to significant harm in the future. This is called the Duty of Candour. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

However, organisations do not legally have to tell you about incidents that cause a ‘low level of harm’ (e.g., minor or short-term harm) or ‘near misses’, so patients will not always be informed if an AAR is taking place.

Where you are informed that an AAR has been held, you will receive a letter after the AAR, explaining what was learned and what changes have been agreed as a result. Add further detail for your context as required

What happens if I am invited to participate in an AAR?

Participation can happen in two ways. You can share your account and this will be read out during the AAR, or you can attend in person, to answer the four questions along with the hospital staff. If sharing your account, a member of staff will speak to you beforehand and write down what you say. This will be read out during the AAR, so that the staff get to learn from your experiences and be able to include this understanding in their planned changes.

If you are invited to attend an AAR in person you will also be able to learn from the experiences of the staff involved and contribute to the discussion about what can be done differently in future, and what should be done the same.

The benefits include:

1. Staff learn first-hand where the care or treatment did not meet expectations and what was experienced by you, the patient and the family. First-hand learning such as this has the greatest and most lasting impact and is a powerful way to improve the safety of patients in the future.
2. You hear first-hand what staff expected to be able to do and what actually happened. This will help you know more about what went on. Many patients and families report that knowing more about what staff were doing is reassuring and helps them recover.
3. You are able to contribute to the plans for improvement and change, to prevent similar problems happening to other people in future.

If you are invited to participate, the AAR Conductor will arrange the AAR at a time that suits you and talk you through what to expect on the day. Most AARs last an hour or so and it’s important for you to let them know if there is anything or anyone you need to help you feel at ease.

AARs normally take place in a meeting room away from the wards but some may be held remotely via MS Teams. Up to 8 staff will participate in the AAR, and you are very welcome to bring someone with you for support.

The AAR Conductor will ensure that all those participating will be able to speak and to be listened to, and that this is done in a respectful and professional manner. It is their role to ensure the same questions are asked of everyone, and that all can contribute to the learning and planning for changes.

What happens after I participate in an AAR?

You will be sent a letter summarising the lessons learned and the actions agreed after the AAR. This information will also be shared with the other participants in the AAR and the *Quality and Safety Lead*, who will be responsible for overseeing the changes that were agreed.

We hope that you will also let us know what you thought about participating in the AAR, what you found most interesting and helpful and where we might improve the process.

We understand that you may feel anxious about talking about your experience with the people who have been treating you/your loved one and would like to assure you that your participation in an AAR will not negatively affect any future care you receive from us.

Additional Help and Support

Assistant Director of Nursing (Safety)

Telephone:

Patient Advice and Liaison Service

Telephone:

We can supply this information in other formats, in larger print, on audiotape, or have it translated for you. Please call the Patient Advice and Liaison Service (PALS) on …………or the Health Information Centre on