Learning culture

Quality statement

We expect providers, commissioners and system leaders live up to this statement:

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

What this quality statement means

- Safety is a top priority that involves everyone, including staff as well as people using the service. There is a culture of safety and learning. This is based on openness, transparency and learning from events that have either put people and staff at risk of harm, or that have caused them harm.
- Risks are not overlooked or ignored. They are dealt with willingly as an opportunity to put things right, learn and improve.
- People and staff are encouraged and supported to raise concerns, they feel confident that they will be treated with compassion and understanding, and won't be blamed, or treated negatively if they do so.

- Raising concerns helps to proactively identify and manage risks before safety events happen.
- Incidents and complaints are appropriately investigated and reported.
- Lessons are learned from safety incidents or complaints, resulting in changes that improve care for others.

I statements

I statements reflect what people have said matters to them.

- I feel safe and am supported to understand and manage any risks.
- I can get information and advice about my health, care and support and how I can be as well as possible - physically, mentally and emotionally.

Subtopics this quality statement covers

- Organisational learning and actions
- Continuous improvement
- Duty of candour

Also consider

- Freedom to speak up

Related regulations

Regulated Activities Regulations 2014

- Regulation 12: Safe care and treatment

- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 20: Duty of candour

Best practice guidance

We expect providers to be aware of and follow the following best practice guidance.

Organisational learning and actions

Learn from patient safety events (LFPSE) service (NHS England)

Patient Safety Incident Response Framework (NHS England)

Introducing National Patient Safety Alerts (NHS England)

Human factors: Learning organisations (HSE)

Reports to Prevent Future Deaths (Courts and Tribunals Judiciary)

The Yellow Card scheme: guidance for healthcare professionals, patients and the public (Medicines and Healthcare products Regulatory Agency)

Duty of Candour

Regulation 20: Duty of candour

Duty of candour animation (NHS Resolution)