Health Services Safety Investigations Body

Webinar summary

After Action Review

Date Published:
23/01/2025

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What is After Action Review?

After Action Review (AAR) is a framework for debriefing from events.

An AAR is structured around four questions:

- What was expected?

- What actually happened?
- Why was there a difference?
- What has been learnt?

Research about AAR has shown trained facilitators are critical to their success in terms of learning, improvement and the creation of a safety culture. Poorly conducted AAR have been linked to increased blame.

Our After Action Review course

We run a half-day 'Introduction to After Action Review (AAR)' course for healthcare staff.

In 2024 there were 872 people who completed our course and many more wanted to attend. We plan to increase our number of courses in 2025. Take a look at our online catalog to check for courses and subscribe to our mailing list to be the first to find out when course booking opens.

A national AAR report template was co-designed and developed in 2024 with volunteers from course attendees and the Health Services Safety Investigations Body (HSSIB) and NHS England.

After Action Review as a tool to learn from patient safety events/incidents

In 2022 NHS England introduced a new patient safety incident response framework (PSIRF). This included the option for healthcare organisations to use After Action Review (AAR) as a way to respond to, and learn from, patient safety incidents rather than carrying out an investigation as they would have previously.

As a result, there has been a significant increase in the recognition and use of AAR as a helpful tool for learning in healthcare, which has created a demand for training in AAR facilitation. For many trusts, AAR has become the most commonly used learning response when incidents happen.

With increasing use of AAR, the benefits – and challenges – of the approach for this purpose are becoming known and there is a thirst to share practice and experience.

Aims of the webinar

To help meet the need to share and learn from the growing community of After Action Review (AAR) facilitators, we decided to hold a webinar.

There were two broad aims of the webinar:

1. Learning from speakers who had significant experience of AAR.
2. Share what is known from research to date about the barriers and enablers to implementing AAR.

Learning from speakers

The first aim was to share learning from speakers who had significant experience of AAR – either in terms of implementing it as a learning response, or of facilitating AAR.

We began by hearing from Lauren Mosley from NHS England's patient safety team, who spoke about why AAR was included in the patient safety incident response framework (PSIRF). This was followed by speakers Emma Emmerson, Patient Safety Specialist and Incident Investigator from Northumbria; Richard Young, Patient Safety Specialist from the Isle of Wight who described their own organisation's journeys in the implementation of AAR adoption and outlined some of the challenges that they had to overcome, as well as looking ahead to their future plans. Next, Lizzie Wallman, Deputy Chief Nurse, and Caroline Walker, Senior Quality Manager, from South-East London Integrated Care System spoke about a cross-organisational, system wide, AAR they had facilitated following an incident.

After hearing these stories, we welcomed Judy Walker, an AAR facilitator and trainer, who spoke about what it means to facilitate an AAR and what support is needed for those taking on this important and often delicate role. Within this talk the challenges of facilitating AARs were described and the importance of the provision of ongoing support to facilitators was demonstrated.

Research to date

The second aim of the webinar was to share what is known from research to date about the barriers and enablers to implementing AAR, and its impact on safety culture including the experience of staff involved in patient safety incidents.

Ireland included AAR in its incident management framework in 2018 and is leading the way both in terms of the resources developed to support AAR facilitation and also in terms of research about the implementation and impact of AAR. We were incredibly fortunate to have Dr Siobhan McCarthy, researcher and healthcare management programme director, Loretta Jenkins, Quality and Patient Safety Manager, and Una Healy, Safety and Risk Manager, at our webinar speaking about these different aspects, as well as sharing the experience of implementation in one Irish hospital where AAR is well embedded.

A key part of the webinar was providing time and space to discuss prominent issues that the attendees were facing. We collated the prominent discussion points that were raised over the course of the morning and presented these as questions to our panel of expert speakers.

Scope of the discussions

We heard of both challenges and opportunities in the use of After Action Review (AAR): both locally, within NHS trust settings, and also when led by an integrated care board (ICB) across different organisations.

The presentations offering these practical examples of AAR prompted attendee curiosity about selection of the most appropriate method, given the varied options of patient safety incident investigations (PSIIs), multidisciplinary teams (MDTs) and swarm huddles. That different strategies might be adopted for similar types of scenarios demonstrates the diverse approaches, priorities and capacities amongst attendees. Furthermore, we also heard about using AAR in conjunction with other methods which will bring new learning as organisations mature and become more experienced in using AAR and other methods.

The practicalities of facilitating AARs was of great interest, and we explored the nuts and bolts of preparing for an AAR by ensuring adequate resourcing e.g. in terms of a dedicated space, protected time, establishing a quorum and the different measures we might adopt to promote staff engagement.

There is still work to do in some areas including assuring psychological safety and support for staff, and in building understanding of the use and value of the AAR process. Naturally this led to rich discussions concerning the complement of facilitator skills needed, as well as the different depth and detail that might be adopted when recording and cataloguing AAR outputs. The scope of ways to document AARs was an area that generated a great deal of discussion. There was

also conversation about the extent to which AARs were recorded and the different templates that were being used. Some organisations incorporated learning through adding additional fields on their incident management systems while others disseminated learning through governance structures.

We also had wider discussions on the involvement of patient and families along with conversations about how coroners are responding to the use of AAR.

Resources

There was much interest in the sharing of resources, both from our speakers and among attendees. Where possible, we have added direct links to these below but would encourage the use of the After Action Review (AAR) page on NHSFutures for further sharing and comment.

Links

- After Action Review report template (HSSIB)
- Patient Safety Incident Response Framework (NHS England)
- Using After Action Review: Guidance for Services (Health Services Executive Ireland)
- Training videos to support After Action Review (BMJ Open Quality)
- Enablers and barriers to After Action Review implementation (Safety Science)
- Impact of After Action Review on safety culture and second victim experience (PLOS One)
- After Action Review resources (including the national AAR report template) (FutureNHS Collaboration Platform)
- Isle of Wight AAR resource (FutureNHS Collaboration Platform)
- Mind the potholes! Implementing After Action Reviews: A blog by the National AAR Reporting Template Team (Patient Safety Learning)
- Should patients be involved in After Action Reviews? (LinkedIn)

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