Letter: Learning from excellence and patient safety incidents

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We agree with Kelly *et al.*'s characterisation of the prominent role and well-known limitations of incident reporting in supporting improvement in healthcare delivery. [1][2]

The positive principles espoused by the Learning from Excellence team, particularly the emphasis on moving away from a blame culture, which can hold back effective learning from adverse incident reporting, are to be encouraged. However, to completely "eliminate the negative" would ignore the human brain's reliance on learning from past errors to improve future behaviours. [3] Therefore, healthcare organisations should aim to learn from *both* suboptimal and excellent care. The challenge for improvers is to invest the resources to: maximise the usefulness of data provided, analyse the data in a way that informs improvement agendas, feedback data and learning to reporters and demonstrate that their concerns have been addressed. [4] Kelly *et al.*'s approach addresses each of these four challenges by allocating significant resources to learning and, consequently, has shown promising results at a local level.

Our multidisciplinary team of researchers have analysed over 50,000 incident reports drawn from a national database to identify priority issues for improvement. [2] Our findings have been valuable in setting priorities in paediatric primary care, vaccination provision and hospital discharge. This work highlighted shortcomings in training, provision for vulnerable groups and IT infrastructure. [2]

This demonstrated that there is valuable learning to be gleaned from structured analysis of incident reports at a national level, whilst Kelly et al show the utility of such approaches locally. The ongoing challenge for policymakers is to allocate adequate resources to facilitate learning at all levels, whether from positive or adverse incidents.

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