

Appendix 1 Bradford Teaching Hospitals NHS Foundation Trust: A learning organisation: Precursor events and associated learning

1.1 Precursor event: Significant Concern

Learning question	Source	Mechanism	Action	Learning outcome
How do we inform all relevant staff of the immediate action they need to take in relation to issues and concerns relating to the use of the Electronic Patient Record?	The command and control structure put in place to support the implementation of the Electronic Patient Record	Silver Command	Issues of significant concern were escalated to Silver Command	A distinctive 'red border email' relating to the issues identified was published (see Appendix 1) and a dissemination process using face to face contact with key staff across the Trust was implemented as necessary
Do we adequately ensure the safety and security of babies on the Maternity Unit?	CQC Inspection	Issues of significant concern were identified during the CQC unannounced inspection.	Escalated to Executive Management Team	Risk assessments undertaken in relation to egress and safeguarding. Requirements to fully test systems related to the prevention of infant abduction fulfilled Importance of every staff member being aware of their role emphasised.
Are the infection prevention and control mechanisms in our theatres effective and consistent?	CQC inspection	Issues of concern were identified during the CQC unannounced inspection.	Escalated to Executive Management Team QuOC	Previous interventions in relation to the findings of a 'peer review day' had not been effective and assurance was not adequate. A review of how we place value on assurance will be undertaken during Q1 2018/19 and presented to all Sub-committees A theatre summit process was initiated. An action plan has been developed, as well as focusing on the actions needed to be taken, which focuses on the 'blocks' within the organisation to effecting change in this case the relationship with Estates and Facilities.

Learning question	Source	Mechanism	Action	Learning outcome
Is the process by which information sharing with primary care through the Trust's EPR effective and resilient?	Serious Incident	Serious Incident	Escalated to QuOC	An unforeseen error caused a backlog in documents being transferred to primary care. An enhanced mapping and reporting assurance system was put in place. Reports from primary care of delayed documents coming into the organisation were adhoc and fragmented, making it difficult to understand the scale of the incident. As a result the system for feedback to the Trust from primary care has been strengthened.
Do we use the outcome of national audits to effectively identify services that may be providing sub optimal care?	Sentinal Stroke National Audit Programme (SSNAP)	National audit report and evaluation	Escalated to QuOC and EMT	A review of the management of the national audit programme across the Trust will be conducted during Quarter 1 2018/19, with an additional focus on the risk assessment completed, as audits are published and the contextualisation of the outcome measures identified with other outcome measures. In addition a review of the conduct of national audits is being undertaken to ensure that data quality is good.

1.2 Precursor event: Concern

Learning Question	Source	Mechanism	Action	Outcome
How can we ensure the quality of care of patients who are being cared for 'out of specialty'	Concerns identified by staff, incidents	IPMG L&SH Daily Huddle QuOC	Escalated to QuOC	A specific programme ('buddying') of clinical review and assessment of patients being cared for out of specialty has been implemented
How can we improve the timeliness and consistency of RIDDOR reporting?	Incidents and evidence of delays in reporting	H&S Committee Daily Huddle		Awareness campaign developed, revised flow chart consulted upon and implemented
Are we providing high quality care to young people who are cared for on adult wards?	CQC Provider Information Return	Assurance team	Escalated to QuOC	Protocol developed and risk assessment completed
How can we improve our performance specifically in relation to VTE risk assessment?	VTE Group	VTE Group	Escalated to Learning and surveillance hub	Learning matters issued
How can we ensure the safety of patients when we are using thickening agents?	Near miss incidents	Daily Huddle	Escalated to Learning and surveillance hub	Learning matters issued Escalated to divisions for discussion and awareness raising at safety huddles
How can we ensure the quality of care of end of life patients that require a McKinley syringe pumps.	Near miss incidents identified by palliative care team	L&SH	Learning matters developed	Learning matters issued Initial feedback has seen a rise in staff accessing the training and contacting the Palliative Care team for advice.
How can we reduce our mislabelled blood samples within the Division of Women's and Children's?	Divisional Quality and Safety meeting	Divisional governance	Newsletter Training Awareness raising	A W&C Learning for all issued Education via supervisor support Awareness poster developed using images to attract staff was felt to be effective and approach to be considered during Q1 2018/19, needs to be consistent with the organisations approach to learning. In addition this learning should be shared across the Trust.
How we can ensure that oxygen is prescribed every	CQC inspection	Executive Management team	Red border email	It is recognised that the prescribing of oxygen, pre the launch of EPR was sub optimal. The EPR

Learning Question	Source	Mechanism	Action	Outcome
time it is required?			Compliance audit	provides an opportunity for simple contemporaneous audit and assurance and intervention in relation to prescribing
How can we ensure second order change in relation to our recording of VTE assessments on EPR?	Routine performance data	Executive Management team	Executive led change programme	The use of contemporaneous ward level data from the EPR has been the key to the improvements in recording of VTE assessments, through being able to target specific poorly performing areas in a timely way. The second order change could be replicated for other areas of patient risk assessment and care management.

1.3 Precursor Event: Opportunities for change and improvement

Learning question	Source	Mechanism	Action	Outcome
Are our action plans that are developed after Serious Incidents and Complaints effective?	Serious Incident and Complaint Investigations	IPMG QuOC Commissioners CQC	Quarterly report to Q&S Committee and CCG Newsletter publication to describe impact of changes made trust wide	Assurance reviews of the effectiveness of action plans developed after serious incidents have occurred are routinely undertaken and identify how effectively the organisation has responded to the recommendations made. Quarterly "Responding and Improving" publication produced and disseminated through corporate communications and divisional governance
How do we explain our approach to learning from death and our work in relation to mortality?	Mortality sub-committee	Mortality sub committee	Escalated to Learning and surveillance hub	Learning matters issues
Are our action plans that are developed after Serious Incidents and Complaints effective?	Serious Incident and Complaint Investigations	IPMG QuOC Commissioners CQC	Quarterly report to Q&S Committee and CCG Newsletter publication to describe impact of changes made trust wide	Assurance reviews of the effectiveness of action plans developed after serious incidents have occurred, are routinely undertaken and identify how effectively the organisation has responded to the recommendations made.
How can we ensure we are learning from nationally published patient experience to prevent similar incidents in our Trust?	NHS Resolution publication	L&SH	The LSH discussed the case published and its similarity to a BTHFT incident.	The Hub agreed to draft a Learning Matters for publication in Q1 2018/19

1.4 Precursor events: Good learning practice

Description	Mechanism	Learning and Surveillance Hub assessment
The Standardised Structured Judgement Review (SJR) process used in mortality reviews enables a comprehensive and consistent approach to the clinical review of cases where a serious incident or incident is suspected	A successful pilot process has been completed between the Medical Directors Office and the Risk Management Team	Consistency to support decision making is key, this may also support preparation for inquests and claim management.
NHS Resolution is sharing the experience of patients involved in incidents or claims, to help prevent a similar occurrence happening to patients, families and staff. The case stories require the consideration of 'Could it happen here?'	NHS Resolution publication	The Learning and Surveillance Hub will routinely review the case stories and ask; <ul style="list-style-type: none"> • Could this happen in my organisation? • Who could I share this with? • What can we learn from this?
Are we maximising the learning from the Structured Judgement Review process?	The Learning and Surveillance hub receives regular feedback from the SJR process and contextualises, the learning in relation to our precursor events.	The Learning and Surveillance Hub suggested that a Responding and Improving issue should focus on learning from mortality reviews and incidents involving the death of a patient. This will be published during Q1 2018/19
Have we got the process in place to enable us to learn from the investigations undertaken by the Health Care Safety Investigation Branch?	The HSIB produce interim reports with safety issues identified in the early phase of investigation and final reports with learning for all organisations.	The Learning and Surveillance Hub will receive all safety issues from interim briefings from the HSIB and all the final reports and consider their implications.