

Meeting Title	Board of Directors		
Date	13.9.18	Agenda item	Bo.9.18.27

Bradford Teaching Hospitals NHS Foundation Trust: A learning organisation (Quarters 3 and 4 2017/18)

Presented by	Tanya Claridge, Director of Governance and Corporate Affairs		
Author	Tanya Claridge, Director of Governance and Corporate Affairs		
Lead Director	Tanya Claridge, Director of Governance and Corporate Affairs		
Purpose of the paper	This paper provides the Board of Directors with a summary of learning from precursor incidents during Quarters 3 and 4 2017/18		
Key control	This paper is a key control for the strategic objective to provide outstanding care for patients and to be a continually learning organisation		
Action required	To note and gain assurance		
Previously discussed at/ informed by	This paper is an output of clinical divisional governance and the work of the Trust-wide Learning and Surveillance Hub		
Previously approved at:	Committee/Group	Date	
	Quarter 3: Quality Committee	28 th March 2018	
	Quarter 4: Quality Committee	27 th June 2018	
Key Options, Issues and Risks			
During the latter part of 2016/17 the Trust identified the need for a knowledge management framework to support learning from ‘precursor events’ (which can be complaints, incidents, claims, inquests, mortality reviews, tacit knowledge and experience of staff etc.). As a result an organisational learning response system was developed, and was presented in a specific paper to the Board of Directors in July 2017.			
Analysis			
This paper provides an overview of the learning generated through the organisational learning response system, its precursor ‘incident’, the learning itself and the modality used to disseminate it across the Trust. This report provides a summary of the Trust wide learning during Quarters 3 and 4 2017/18.			
The Trust, during Quarter 3, remained focused on the continued safe implementation of the Electronic Patient Record and preparation for anticipated unannounced and well led CQC inspections during quarter 4 2017/18. Due to the volume of work required of the team and other staff involved in the learning hub during quarter 4, specifically related to winter and three consecutive CQC inspections only one learning matters was produced.			
There is now a standing item on the Quality Committee agenda which relates to the Quality Oversight System. This provides the Committee with a more contemporaneous summary of the work of the Learning system in addition to the quarterly report that is received.			
Recommendation			
The Board of Directors is asked to note this report and gain assurance in relation to operation of the quality oversight system			
The Board of Directors is asked to consider whether it required a more detailed presentation in the future from staff involved in learning form precursor incidents describing and evidencing the impact that it has had			

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments		▪
Quality implications		▪
Resource implications		▪
Legal/regulatory implications		▪
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: <i>Safe, caring, effective, responsive, well led</i>
Care Quality Commission Fundamental Standard: All
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
	▪				

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1 PURPOSE/ AIM

This paper provides the Board of Directors with a summary of learning from precursor incidents during Quarters 3 and 4 2017/18.

2 BACKGROUND/CONTEXT

This report has been prepared to provide a tangible output from the Trust's organisation learning response system during 2017/18. The system is designed to process information from multiple sources, identify opportunities for learning from 'precursor incidents' identified within the information processed, develop an agreed modality for that learning to be shared, share the learning and test and assure the effectiveness of the methods used.

The report does not purport to include all organisational learning across the Trust during the specified time period for a number of reasons:

- One of the principles of the learning and response system is the absolute recognition that most organisational learning is informal, and the system should serve to strengthen that learning, not try to measure it.
- The learning and response system is new and evolving.
- It is designed to provide a pen portrait of learning, other learning is routinely described in reports and papers presented throughout the Trust.

3 PROPOSAL

For the purposes of this report learning and learning outcomes are presented in relation to the risk associated with the precursor event that was identified within the system (see Appendix 1).

- 1: precursor events where there was significant concern
- 2: precursor events where there was concern
- 3: precursor events where there were opportunities for change and improvement
- 4: precursor events where good practice in learning was identified

To support the assurance examples of how learning was disseminated or actioned are provided. These examples take the form of alerts, safety information dissemination, information about action taken and descriptions of local improvement actions. Those published during quarter 3 and 4 2017/18 are presented in Appendix 2 (learning matters) and Appendix 3 (responding and improving)

The Trust now has a dedicated intranet site for Learning,
<http://nww.bradfordhospitals.int/departments/Learning/Pages/Learning-Home-Page.aspx>

During Quarter 4 2017/18 the Learning and Surveillance Hub worked to rebrand and expend the 'Matters' document profile, examples can be found in Appendix 2.

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4 RISK ASSESSMENT

There are no identified risks with the content of this paper.

5 RECOMMENDATIONS

The Board of Directors is asked to note this report and gain assurance in relation to operation of the quality oversight system

The Board of Directors is asked to consider whether it required a more detailed presentation in the future from staff involved in learning from precursor incidents describing and evidencing the impact that it has had

6 Appendices

Appendix 1: Precursor incident and associated learning quarters 3 and 4 2017/18

Appendix 2: Learning Matters published quarters 3 and 4 2017/18/ Learning Matters rebranding

Appendix 3: Responding and Improving Quarter 4