Mid Essex Hospital Services NHS
NHS Trust

Learning from Experience Policy	**Type: Policy** **Register No: 10088** **Status: Public**

Developed in response to:	Best Practice,
Contributes to CQC Fundamental Standards	12, 16, 17

Consulted With	**Post/Committee/Group**	**Date**
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Version Number	4.1
Issuing Directorate	Governance
Ratified by:	DRAG Chairman's Action
Ratified on:	7th June 2016
Executive Sign Off Date	June 2016
Implementation Date	7th June 2016
Next Review Date	Extension agreed to December 2019
Author/Contact for Information	H Clarke, Head of Governance
Policy to be followed by (target staff)	All staff
Distribution Method	Intranet & Website
Related Trust Policies (to be read in conjunction with)	Risk Management Strategy and Policy Incident Policy Serious Incidents Requiring Investigation Policy Complaints Policy Claims Policy Clinical Audit Strategy and Policy Being Open and Duty of Candour

Document Review History

Version No	**Authored/Reviewed by**	**Issue Date**
1.0	D Miller	October 2011
2.0	H Clarke	November 2012
3.0	H Clarke	May 2016
4.0	H Clarke	7th June 2016
4.1	Helen Clarke – 6 month extension due to MSE harmonisation	20th June 2019

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1. Purpose

1.1 Ensuring the safety of patients, staff and visitors is a key priority within the Trust. This requires a collaborative approach to the analysis of various quality and safety indicators including incidents, complaints, claims and findings from clinical audit and that the lessons learnt from this analysis are shared across the organisation and wider healthcare community.

1.2 It is essential that staff appreciate that the Trust has a culture of learning and that any investigations undertaken are intended not to blame individuals but to identify causal factors and share lessons learnt to prevent any reoccurrence.

2. Scope

2.1 This policy applies to all members of staff working within the Trust.

2.2 Information on the analysis of individual Serious Incidents, Incidents, Complaints, Claims and clinical Audit is available in the corresponding policies.

3. Aim

3.1 The aim of this policy is to ensure there is a systematic approach to the analysis of incidents, complaints and claims on both an individual and an aggregated basis, and that safety lessons are learnt and shared appropriately. Improvements in practice will occur as a result of the lessons learnt during investigation and analysis.

3.2 To avoid repeating mistakes the Trust must learn from previous similar events. Effective learning will be achieved by utilising all Trust communication systems (i.e. Intranet, Staff Focus, Trust Safety Alerts, staff safety huddles, newsletters, audit meetings clinical Governance meetings, etc) to relay the outcome of investigations and team working to ensure the development of practical plans for improving safety.

3.3 Being involved in an incident, complaint or claim which is under investigation can be a stressful experience. The Trust has a range of counselling and support mechanisms that actively help patients, carers, relatives and staff. Refer to support for staff Policy.

4. Responsibilities

4.1 Board of Directors

The Board has a responsibility to make sure that the analysis of all incidents, complaints and claims is undertaken to optimise the recognition of trends and themes and enable a swift response to such. The Board is also responsible for ensuring that trends and themes are acted upon and managed effectively and that any lessons learnt through the investigation of such incidents, complaints and claims are learnt across the organisation.

4.2 Chief Executive

- The Chief Executive, as accountable officer, is ultimately responsible for ensuring the safety of patients, visitors and staff within the organisation. It is

therefore the Chief Executive's responsibility to make sure that there are robust systems in place to identify trends and themes from incidents, complaints and claims at the earliest opportunity and that measures are implemented to ensure the safety of patients, staff and visitors.

- It is also the responsibility of the Chief Executive to ensure there are robust systems in place to learn lessons across the organisation and the healthcare community where appropriate.

- The Chief Executive is responsible for ensuring that this policy is implemented within all areas of the Trust through responsible Executive Directors, Divisional Clinical Directors, Associate Directors of Operations and Associate Chief Nurses.

4.3 Chief Medical Officer

The Chief Medical Officer is responsible for supporting the Chief Executive and Trust Board in their responsibilities and supporting the Divisional Clinical Directors, Associate Directors of Operations, Associate Chief Nurses,Matrons and Line Managers and medical staff in implementing this policy across the organisation.

4.4 Chief Nursing Officer

The Chief Nursing Officer is responsible for supporting the Chief Executive and Trust Board in their responsibilities and supporting the Divisional Clinical Directors, Associate Directors of Operations, Associate Chief Nurses, Matrons and nursing staff in implementing this policy across the organisation.

4.5 Head of Governance

The Head of Governance is responsible for ensuring a robust process is in place for reporting, investigating and learning from incidents, and for supporting the production of an aggregated incidents, complaints and claims report to identify and share lessons learnt.

4.6 Divisional Clinical Directors

The Divisional Clinical Directors have a responsibility to make sure that the principles outlined within this policy are implemented within the Division including fostering a culture for learning from experience and sharing lessons learnt. They are responsible for disseminating lessons learnt to colleagues within their Division, providing opportunities for learning through team meetings and with colleagues in other Divisions where appropriate.

4.7 All staff

All staff have a responsibility to report issues and concerns identified in their working environment and contribute to the process of learning lessons. They can do this by taking account of the relevant communications, encouraging peers and colleagues and contributing to team meetings.

4.8 **Caldicott Guardian**

The Caldicott Guardian will have responsibility for sharing any learning around incidents involving breaches of patient confidentiality and provides a focal point for patient confidentiality & information sharing issues.

4.9 **Senior Information Risk Owner (SIRO)**

The SIRO is responsible for fostering a culture for protecting and using data and provides a focal point for managing information risks and incidents.

4.10 **Information Governance Manager**

Charged with ensuring all relevant Trust areas are aware of recommendations set by the Information Governance Group in relation to information governance incident investigations.

5. Analysis of incidents, complaints, claims and clinical audit

5.1 The DATIX electronic reporting system allows the information relating to incidents, complaints, claims and Clinical audit to be collated and presented within a report to the Patient Safety and Quality Committee: the Chief Nurse Report.

5.2 The Chief Nurse report will include quantitative and qualitative data and will identify key trends and themes and provide assurance that concerns are being addressed or escalate any unmitigated risks to the Committee.

5.3 Where there is limited assurance that identified issues are being addressed, the Patient Safety and Quality Committee will require action to mitigate these risks. Progress with any actions developed as a result will be monitored at subsequent Patient Safety and Quality Committee meetings. The Terms of Reference for the Patient Safety and Quality Committee are available in the Trust's Risk Management Policy.

5.4 For **Incidents** the data submitted will include:

- Total number of incidents reported by month
- Total number of incidents reported by directorate / specialty
- Top 4 risks as a minimum with additional analysis of subcategories as indicated
- Total number of reported significant incidents by quarter including:
    - incidents reported externally as Serious Incidents
    - 'Never Events'
- Themes of Serious Incidents investigated in the period and key learning points.

5.5 For **PALS and Complaints** the data submitted will include:

- Total number complaints received by quarter.
- Total number complaints received during the quarter by directorate and level of complaint
- Subject of the complaint – top 5 categories to be reported as a minimum

- Number of complaints within top 5 categories by directorate with additional analysis of subcategories as indicated.
- Number of investigations with recommendations
- Number of complaints referred to PHO by quarter and number of complaints upheld
- Summary of learning themes

5.6 For **Claims** the data submitted will include:

- Number of new, ongoing, and settled or closed claims for clinical negligence, public liability and employers' liability by directorate / department and quarter.
- Details of new claims received by directorate / department during the quarter.
- Themes from new clinical negligence claims root cause analysis
- Details of claims settled or closed for the quarter.
- Any new or outstanding recommendations made by the panel solicitor and reported to the NHSLA.

5.7 Other quality metrics reported will include:

- Monthly safety thermometer data
- Ward dashboards
- Updates on key harms
- Clinical Audit - summary of key findings and learning
- Central Alerts
- Safety and quality updates

5.8 The Patient Safety and Quality newsletter will be developed after each Patient Safety and Quality Committee to support increased staff awareness of the key trends and learning points identified.

5.9 The Chief Nurse report will be shared with directorates / departments via the governance meeting to facilitate organisational learning.

5.12 In accordance with each of the individual policies, investigating officers and service leads will, where appropriate, make recommendations as a result of individual incident, complaint or claims investigation and root cause analysis. Action plans are then developed and implemented to address any identified risks. Line managers will ensure that lessons learnt as a result of investigation and root cause analysis are effectively disseminated locally.

6. Sharing Lessons across the Local Health Community

6.1 The Trust recognises the value and importance of ensuring that lessons learnt from its internal process are externally shared to drive up the standards of health and social care throughout the local community. Conversely, the Trust will take steps to actively 'learn' from the outcomes identified from its partner and neighbouring organisations in order to improve its internal processes and practices.

6.2 The Trust will discharge this responsibility through:

- Attendance at regional performance/clinical governance meetings, such as the Clinical Quality Review Group chaired by NHS Mid Essex CCG;
- Reporting of Serious Incidents externally, where appropriate, to the National Reporting and Learning Scheme and NHS Mid Essex CCG;
- Attendance at relevant regional meetings organised specifically for the purpose of shared learning.

7. Risk Reduction Measures

7.1 Process for Implementing Risk Reduction Measures

7.11 The Trust recognises that risk will be identified through investigation and root cause analysis of individual incidents, complaints or claims and analysis of its clinical governance workstreams. The risks identified will need to be mitigated through the implementation of risk reduction measures. Where risks are identified, Directors will be accountable for ensuring that specific actions with named leads and timescales are identified and implemented to address these. This should include mechanisms for local and organisational learning.

7.12 Where significant residual risk is identified, the risk itself and the measures to reduce the risk will be documented within the local Risk Assurance Framework and monitored until all elements of the corresponding action plan have been satisfactorily closed. The full process for the Risk Assurance Framework can be viewed within the Risk Management Policy.

7.13 Where aggregation of incidents, complaints and claims data identifies the need for action at local or organisational level, the Patient Safety and Quality Committee will be responsible for gaining assurance that issues are being addressed with specific actions developed with named leads and timescales. Progress with implementation should be monitored at subsequent meetings.

7.2 Further opportunities for improving practice and reducing risk

7.2.1 The Trust will use the following methods to ensure that lessons learnt are embedded into everyday practice:

- Progress with individual incidents, complaints and claims are monitored at Directorate level and by the respective department i.e. Corporate Governance, PALS, Complaints, Claims and Legal.
- The Serious Incident Management Group (SIMG), Clinical Governance Facilitators and the Governance Department monitor the progress of action plans identified during a serious incident investigation.
- SIMG will monitor whether recommendations arising from investigations and reviews are being disseminated and acted upon across the Trust and whether improvements are embedded into everyday practice.
- Planned local and Trust audits will be undertaken to assess whether learning has been embedded into everyday practice.
- The annual staff and patient surveys will be reviewed for information relating to patient safety.

- The Governance and Clinical Effectiveness Teams will facilitate audits of changes in practice in response to the lessons learnt and recommendations as part of the annual audit programme.
- The outcome from completed incident investigations will be communicated to the incident reporter via DATIX (dependent on the reporter including a Trust email address)
- Learning outcomes form incidents are also shared during the “debrief” stage of the incident investigation process.
- Trust Safety Alerts will be developed for serious incident investigations

8. Equality & Diversity

8.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

9 Training

9.1 All relevant staff are trained on the use of DATIX for incident reporting and relevant risk management.

9.2 Risk management, Incident and PALS and complaints training all promote the relevance of learning lessons from feedback to improve safety and service provision with a view to improving the patient experience.

9.3 Training is provided in accordance with the Mandatory Training Policy (TNA).

10. Audit and Monitoring

10.1 Compliance with this policy will be monitored on an on-going basis.

10.2 Formal review will be undertaken within the annual assessment of the Patient Safety and Quality Committee against the terms of reference by the Trust Secretary.

11. Communications and Implementation

11.1 This policy will be made available on the Trust intranet.

11.2 The Patient Safety and Quality Newsletter will be used to further spread awareness as to the contents of this policy

12. Policy Review

12.1 This policy will be reviewed three yearly or earlier in response to national or local initiatives.