Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 98/14

Title:	**Policy for sharing learning**			
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Ownership:	Cathy Jack, Medical Director			
Approval by:	Trust Policy Committee		**Approval date:**	June 2014
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Version No.	V2	**Supercedes**	V1 – June 2014- March 2015	
Key words:	Incident, Serious Adverse Incident, SAI, Learning, Investigation, Action Plan, Complaint, Litigation, Incident feedback, Sharing learning, Shared learning, Mortality and Morbidity			
Links to other policies	- Adverse Incident Reporting & Management Policy - HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013 - Complaints and Compliments Policy - Claims Management Policy - General Health & Safety Policy and other specific Trust Health & Safety Policies			

Consultation with:

- SAI Group
- Claims Review Group
- Complaints Review Group
- Outcomes Review Group
- Standards & Guidelines Committee
- Medicines Management Group
- Safety Improvement Team
- Strategic Group for Quality Improvement & Development (SQUID)
- Deteriorating Patient Group

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy covers learning identified from internal sources such as incidents, litigation, complaints and compliments, Mortality and Morbidity meetings, and also learning from external sources such as NIAIC, other HSC Trusts and Learning Letters from Commissioners.

When an incident occurs or a patient/client has sub-optimal experience in our service or in another Trust we owe it to our service users and ourselves to learn from such events and reduce the chance of similar experiences happening again.
Sir Liam Donaldson, speaking on patient safety, said in 2007: -

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Learning obtained from incidents can be defined as safety, practice and process issues which have contributed to the incident but from which others can learn. Examples of learning from an incident are:

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations.
- Good practice which reduced the potential impact of the incident.
- Early detection or intervention which reduced the potential impact of the incident.
- Lessons from conducting the investigation which may improve the management of investigations in future.

Learning may also be derived from a number of other sources, including a complaint or compliment, mortality review, litigation, audit, regional learning shared by DHSSPS / HSCB.

1.2 Purpose

This policy outlines how learning should be captured and shared in the Belfast Health & Social Care Trust.

1.3 Objectives

1.3.1 To ensure that learning is shared with all parts of the organisation to which it applies.

1.3.2 To keep and make available a central repository of learning on the hub.

2.0 SCOPE OF THE POLICY

This policy applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency staff, contractors and volunteers.

3.0 ROLES/RESPONSIBILITIES

Corporate Governance will take responsibility for receiving all Trust-wide learning from the various sources. They will be responsible for dissemination to Directorates and for maintaining a central repository of all learning shared.

Directors will be responsible for ensuring that all Shared Learning received is disseminated to teams and relevant staff. As well as the dissemination of learning via email, it is important that learning is discussed with clinical teams if relevant for the specialty or at Directorate governance meetings.

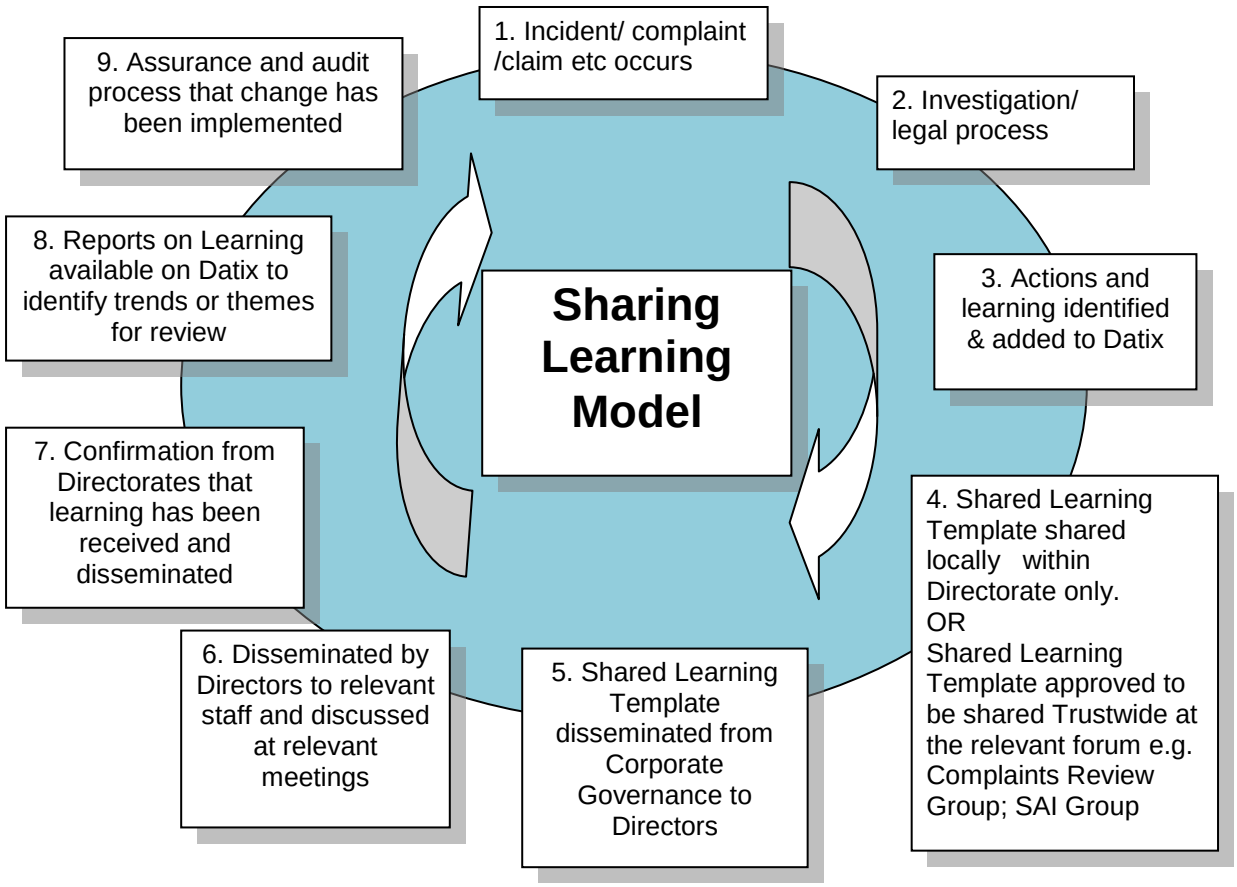
4.0 KEY POLICY PRINCIPLES

4.1 Sources of Learning

Learning may be derived from a number of sources. These are:

- An incident or Serious Adverse Incident,
- a complaint or compliment,
- a morbidity / mortality review case (including Cardiac Arrest reviews),
- a litigation case,
- an audit,
- A Case Management Review (child protection),
- Events in other Trusts sometimes result in a learning letter from that Trust, the Health and Social Care Board (HSCB) or the DHSSPS,
- Concerns raised by staff.

4.2 The Shared Learning Model



4.3 Incident Investigation

4.3.1 Incidents (except Serious Adverse Incidents (SAIs))

All incidents must be investigated as per the Trust Incident Investigation Procedure (excluding SAI's) and any identified learning shared as set out in section 4.4 below.

4.3.2 SAIs

All SAIs must be investigated as per the HSCB Procedure for the reporting and follow up of SAIs October 2013, using the investigation report templates contained within that procedure. The templates for Level 1and Level 2&3 type investigations include a section on Lessons Learnt.

Within investigation reports it is important that:

- Learning is clearly identified and addressed by the recommendations and relates to the findings.
- A learning section should indicate to whom learning needs to be communicated.

4.3.3 Action Plans
Action plans in response to SAIs, Complaints, Audit, etc., should include actions for sharing of lessons learned from investigations as appropriate.

4.4 Types of Learning
4.4.1 Local learning (ward/department)
Learning deemed relevant only to the area or department where the incident or complaint occurred should be discussed at the local staff/team meeting and recorded on the Datix system. The incident approver on Datixweb should ensure the learning is entered in the appropriate field within the Investigation section of the incident form along with any investigation completed and action taken.

4.4.2 Shared Learning within Directorates
Often learning from incidents or complaints will be relevant to other areas across the specialty or Directorate where the incident occurred. In these circumstances the learning should be shared via Directorate assurance structures and Governance groups as well as using the Datix system as above to ensure learning is captured. The learning should be included on Directorate governance agendas and discussion/action noted in minutes (for audit trail).

Where learning is relevant beyond the Directorate responsible, a Shared Learning Template (see 4.4.3) may be used in addition to the methods above. This should be discussed and approved at the relevant Group within the Assurance Framework and reported through to the Learning from Experience Steering Group which provides assurance that learning is shared appropriately.

4.4.3 Shared Learning Template – Trustwide
A Shared Learning Template is a communication tool to enable one service to share learning from an adverse incident, complaint, or other event, with other relevant services. The Shared Learning Template will usually be a one page document (see Appendix 1). This can be easily read, displayed and filed.

Shared Learning Templates should not name staff or the specific unit where the event occurred. Patient/client/service user confidentiality must not be breached and information is shared within the confines of the Data Protection Act.

Learning that is deemed relevant to other Directorates should be tabled by the Director / Co-Director at the relevant meeting, such as SAI Group, Complaints Review Group, etc., or at the Learning from Experience Steering Group for a decision for sharing across the Trust. If approved for sharing, the Shared Learning Template will then be disseminated by the Corporate Governance department to the relevant Directorates. Confirmation that learning has been received and disseminated will be sought by the Corporate Governance team. Please see flowchart in Appendix 2. All Shared Learning Templates disseminated will be available on the Risk & Governance webpage on the Hub.

4.4.4 Regional shared learning

The Trust receives and is expected to act upon Learning Letters from HSCB, DHSSPS or other agencies and from external/regional audit findings. External Learning Letters will be disseminated from the Corporate Governance department to Directors for onward dissemination.

The HSCB has a responsibility to share learning across regional HSC organisations as appropriate. However, if the Trust has identified learning that other Trusts should be alerted to urgently this should be shared promptly from Trust to Trust.

4.4.5 Other methods of sharing learning within the Belfast Trust

Safety Matters is the Trust newsletter relating to improving the safety and quality of services and sharing learning from incidents and other events.

Safety Message of the Week is published weekly on the hub and is discussed at relevant governance meetings. All teams across the Trust can contribute safety messages for publication.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

Following approval, the policy will be disseminated widely. Implementation will begin immediately through issuing of shared learning from Corporate Governance.

5.2 Resources

The dissemination of learning templates from Corporate Governance will initially be done via e-mail. Corporate Governance are exploring using DATIX to issue the learning as this would support a process where we could formally close off that learning has been shared (as it is used for medical device alerts). This will be investigated and may require some resource.

5.3 Exceptions

None.

6.0 MONITORING

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Accountability/Performance Management Reviews
- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Controls Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident Group
- Claims Review Group
- Complaints Review Group

Learning that is to be shared Trustwide, from any source, will be formally signed off by Directorates. Co-Directors / Governance & Quality Managers will confirm that the Shared Learning Template was received and disseminated appropriately. Co-Directors / Governance & Quality Managers will provide this assurance at the

relevant meeting (SAI Group, Claims Review Group, Complaints Review Group etc), or upon request to the Corporate Governance department. An electronic or online method will be sought for this assurance.

If a Shared Learning Template identifies a gap or inadequacy within a service area this should be highlighted on the appropriate Risk Register and via Directorate governance structures.

7.0 EVIDENCE BASE / REFERENCES

- See Adverse Incident Reporting & Management policy; Complaints and Compliments Policy

8.0 CONSULTATION PROCESS

- Serious Adverse Incident Group
- Claims Review Group
- Complaints Review Group
- Outcome Review Group, including feedback from Morbidity & Mortality Leads.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 – Shared Learning Template
Appendix 2 - Dissemination of BHSCT Shared Learning Templates

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date:** _____

Author

_____ **Date:** _____

Director

Appendix 1

Shared Learning Belfast Health and Social Care Trust caring supporting improving together	**Incident/SAI/Complaint/ Compliment/Audit/ External Letter/ M&M Review/ CMR/Litigation Ref. No.**	**Date issued:**
Safety Message:		
Summary of Event		
Learning Points		
Learning applicable to:		

Specific Directorate(s) (specify):		Trustwide	
Other (specify):		Regional	

Action Required (*for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group*)		
Approved by:	Designation:	Date approved:

Appendix 2

DISSEMINATION OF BHSCT SHARED LEARNING TEMPLATES