Patient safety incident response plan

Effective date: 1st November 2023

Estimated refresh date: 31st October 2025

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Authoriser	**NBT Board**	**NBT Board**	**As per minutes of meeting**	**30/11/2023**

Contents

Foreword

Ensuring the safety and well-being of every patient is the cornerstone of any healthcare system, and it is with pleasure that I present this Patient Safety Incident Response Plan. In today's rapidly advancing medical landscape, our commitment to patient safety stands unwavering, fuelled by the collective efforts of compassionate healthcare professionals.

This Patient Safety Incident Response Plan reflects the commitment of our healthcare organisation to continuously improve our practices, prevent harm, and enhance patient outcomes. Within these pages, you will find a blueprint designed to foster a culture of safety, underpinned by evidence-based strategies, and the pursuit of excellence. Our Plan recognises that safety is not a solitary endeavour, but a collective responsibility shared by every member of our healthcare community.

In drawing together this plan we have reflected on the successes of the last two years. This updated version is a continuation of implementing PSIRF following our role as an early adopter within the NHS. In that time, we have developed our understanding of how to proportionately respond and utilise other ways to learn. For example, our recent thematic review of never events has received positive feedback across our region. While looking at our successes we have reflected on the areas we need to improve. The need to provide our staff with the right environment, skills to reflect and identify learning, and how to collaborate with patients and families through the safety processes are key parts informing the future of our work.

By emphasizing transparency, communication, and the active involvement of patients and their families, we aim to forge a partnership that places patient safety at the forefront of decision making, action and the future design of services. This document outlines how we will respond proportionately to safety incidents and ensure our resources are used in the best way possible, enabling the focus to be on the delivery of change.

As you engage with this Plan, I encourage you to embrace the principles of positive patient safety, consider its impact on your daily practice, and become an ambassador for what we are aiming to achieve. By doing so, we will collectively foster an environment where patients are confident in knowing they are receiving the safest, most compassionate care possible.

I extend my deepest gratitude to every member of our healthcare team, whose dedication and expertise support safe care. It is your unwavering commitment to the well-being of our patients that drives us forward and serves as a beacon of hope for those we are privileged to serve.

I hope this Patient Safety Incident Response will function as a catalyst to inspire a culture of curiosity, and continuous improvement, where patients and our staff work together for the betterment of the NHS.

Tim Whittlestone
Medical Director
North Bristol Trust
July 2023

Introduction

We are delighted to present our second Patient Safety Incident Response Plan for North Bristol NHS Trust (NBT).

This patient safety incident response plan sets out how we intend to respond to patient safety incidents over the next of 12 to 18 months, building on the work as an early adopter and implementing the new patient safety framework over the last two years.

The Patient Safety Incident Response Framework (PSIRF) sets out a renewed focus on learning and improvement, with the emphasis placed on the system and culture that support continuous improvement and patient safety management. The underpinning principles of PSIRF is recognising a proportionate approach to responding when incidents occur, utilising a data-driven approach which prioritises engagement with those affected, and the need to embed a system view of learning that considers every aspect of how healthcare services are delivered when incidents are identified.

Our Patient Safety Incident Response Plan is one part of delivering the overall vision for North Bristol NHS Trust by delivering outstanding patient experience that puts the patient first.

Through adoption of this plan, PSIRF aligns to our strategic objectives and priorities through figure 1. This strategy embraces continuous improvement, which we call our 'Patient First approach'. This approach focuses deeply on a small number of Improvement Priorities, developing improvement capability across the organisation, and living our NBT Values through our behaviours.

Over the last two years we have developed our understanding and insight to patient safety. Our journey is an ongoing one where we will

adapt and adopt new ways to understand how our systems function. In adopting this plan, we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Fig 1: PSIRF Alignment to North Bristol NHS Trust Strategy	
Improvement Priority	**PSIRF Alignment**
High Quality Care: Better by Design	PSIRF is all about patient safety which is integral to quality. In applying systems thinking to our patient safety practice, this will improve how we understand variation in delivering care and influence the development of new ways to provide services for patients.
Sustainability: Making best use of our limited resources	Through utilising PSIRF we look at improvement to maximise the potential of available resources.
People: Proud to Belong	Through creating psychological safety, trust and adopting a just culture, we will empower our staff to reflect with openness, improve resilience and create satisfaction through influencing tangible change to their work areas.
Commitment to our Community: In and for our community	PSIRF advocates a closer relationship with those affected by patient safety to listen and engage them actively in learning.

Our services

NBT is a centre of excellence for health care in the Southwest as one of the largest hospital trusts in the UK with tertiary specialist services and district general services. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

NBT is a complex system with many interrelated components that are crucial to ensuring that everything works. We have reviewed all patient safety activities and our network of key stakeholders across NBT who are integral to the Patient Safety agenda.

This Trust has 7 Corporate Directorates. The central Patient Safety Team works alongside the Patient Experience Team. Quality Audit & Assurance Team and Quality Governance Systems Team, within the Nursing & Quality Directorate.

There are 5 clinical Divisions consisting of Medicine, Women and Children's Health (WCH), Neurosciences and Musculoskeletal (NMSK), Anaesthesia, Surgery Critical Care and Renal

(ASCR) and Core Clinical Services (CCS). These are supported by Divisional Quality Governance and Patient Involvement & Experience teams. These teams provide operational support, working collaboratively with the central governance, safety, and experience teams.

Core patient safety activities undertaken at NBT include:

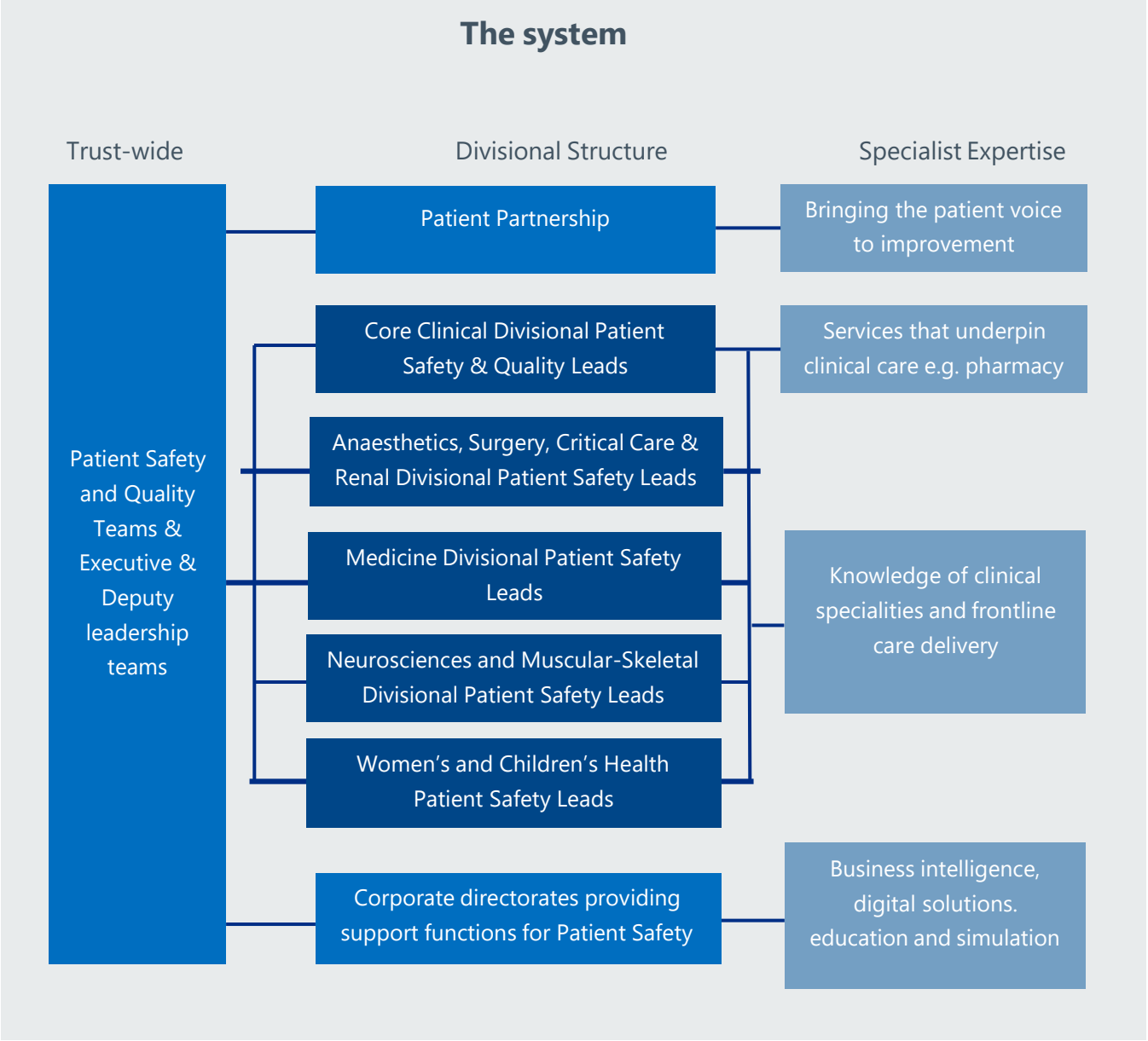
- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Supporting improvement programmes
- Providing a range of patient safety training
- Compliance with Duty of Candour
- Involving patients and families in keeping themselves safe
- Implementing actions in response to patient safety incidents.

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths, Freedom to Speak Up, complaints and other patient or carer feedback and inquest responses.

The operational 'work-as-done' for these patient safety activities is predominantly owned by our colleagues on the front-line. This is teamed with support from their respective Divisional Quality Governance colleagues who are supported through strategic, educational and subject matter expert support flowing from the Corporate Directorates.

This system has been built to fit and respond to the size of hospital we are and the nuances of the teams, services and structures we work in. We call this system our 'Patient Safety Network'. This involves key people & teams within NBT who are integral in facilitating our patient safety system and patient safety culture, on our road to implementing PSIRF.

System overview – our networks

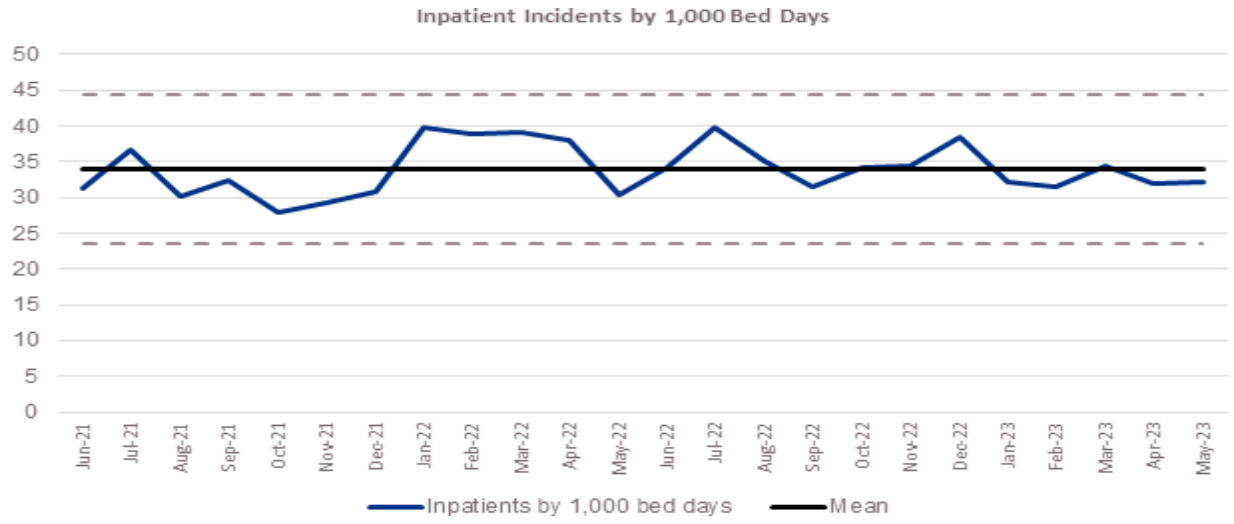


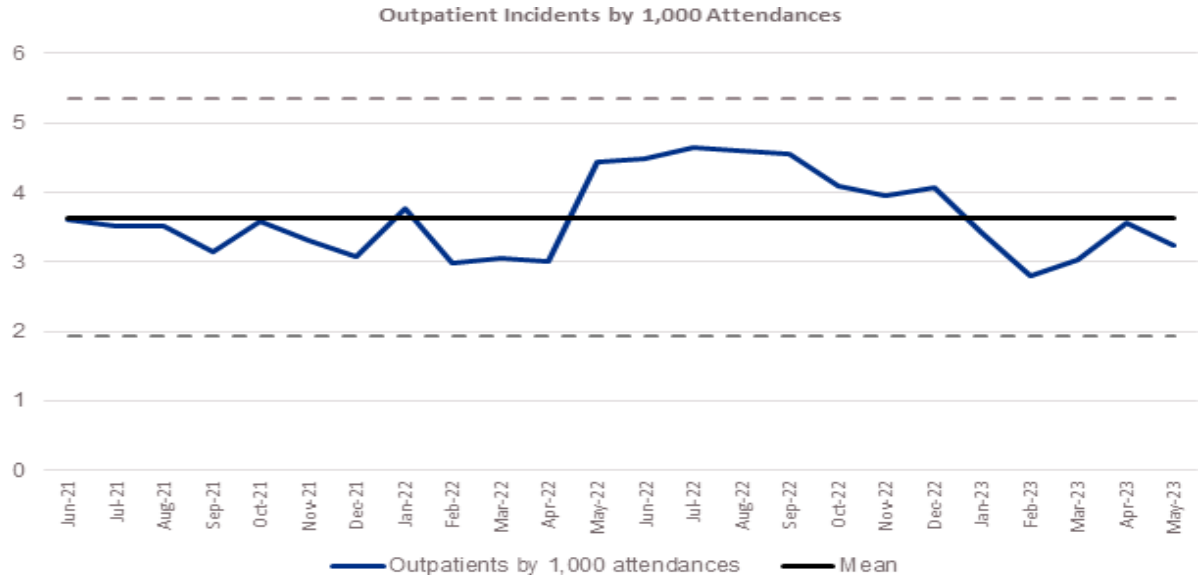
Situational Analysis of Patient Safety Activity

Historically, NBT reported more than 36,000 patient safety incidents, with less than 0.4% of them being investigated as serious incidents under the framework pre-dating PSIRF. A large proportion of these were time consuming and a disproportionate amount of time was spent carrying out serious incident investigations limiting the trust's ability to learn thematically or implement change.

A key part of developing our approach is to understand the amount of patient safety activity the trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes in place.

Over the last two years the rate of reporting for inpatient incidents has been impacted by the Covid-19 pandemic and the resulting capacity and flow challenges. The biggest extended peak in incident reporting began at the height of the second wave of the pandemic from January 2022 to April 2022. The last six months has seen a more consistent reporting rate.





In the 2021-23 PSIRP, the local priorities identified were:

- Inpatient falls
- Medication
- Responding well to clinically changing conditions
- Pressure injury
- Discharge

The Patient Safety Incident Investigation related activity undertaken can be broken down as follows:

Activity	Definition	Number completed in the last 2 years	Average over last 2 years
Incidents Resulting in Death	incident requiring investigation which met the standard investigation timeframe and resulted in patient's death.	16	8
Never Events	Incident meeting criteria for never events framework	8	4
Local Priorities/others	Incidents requiring PSII which met one of the identified priorities for 2021-23, or incidents where learning was not well understood.	4	2

In addition, the Trust has tracked 15 incident which resulted in investigations led by HSIB.

Within our previous PSIRP covering 2021-2023 the trust identified that it expected to undertake 20-25 investigations per year. Over the last two years we conducted less than the expected level with a total of 28 PSII.

Due to the impact of COVID and recovery of services in the aftermath of national lockdowns, it has not been possible to advance the local priorities thematic analysis and improvement programmes as much as expected. This is reflected in the reoccurrence of a number of these priorities in this refreshed plan and potentially less than expected PSII completed in the last two years.

Defining our patient safety incident profile

In refreshing this plan, our starting position was an understanding that it has not been possible to progress improvement as expected over the last 2 years and we have adjusted to a post-covid position in managing the wider healthcare pressures which has impacted the delivery of

improvement programmes. To define our priorities for 2023-2025 we analysed patient safety incident and investigation data between June 2021 (when PSIRF was implemented) – May 2023 to test any changes or to confirm that the areas of priority remain appropriate. Our original incident profile also considered sources of insight such as complaints, concerns, inquest.

We have also aimed to provide a more nuanced picture of safety incidents for each Division. The hope is that though identifying division specific priorities will enable targeted improvement and empower locally led changes driven by data and patient safety principles. In this plan we have taken the first step towards this through identifying priorities for our Women and Childrens Division.

Shortlisting of our refreshed patient safety priorities was considered alongside identified programmes of improvement work which exist within NBT and are outlined in the next section to identify where we should focus our in-depth insight resource to best effect. The outputs of this process are described in the next section.

In September 2023 this plan was agreed by the Patient Safety Committee and the board sub committee for Quality. In addition, we have also linked with our partners in the Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB).

Defining our Trust patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- The Trust Patient First Programme which has identified organisation-wide improvement areas.
- Existing quality improvement programmes
- Existing Patient Safety Improvement Programmes
- ICS operational improvement projects
- National Patient Safety Improvement programmes
- Learning from the 2021-2023 Patient Safety Incident Response Plan

As part of reviewing our priorities, the trust considered if there is existing in-depth insight about the risk presented and what that might mean if this is de-prioritised; and whether there is an existing workstream of improvement already established with clear understanding of the issues driving the risks to patients.

The outcome of this consideration is below:

Theme from Analysis	Existing Improvement Workstream	Shortlisted as Key Priority for 2023-25	Rationale
Service Provision	Partial	No	This is the most reported category of incident and often relates to service capacity and staffing levels. Staffing recruitment, wellbeing, and retention is subject to improvement

			programmes led by the people team. Capacity and demand is subject to monitoring through operational performance teams. Capacity and staffing challenges are identified within other incident types as contributory factors.
Patient Falls	Partial	Yes	A falls program has been re-started however it is in its early stages of forming. Analysis of trends and themes has commenced with further work needed to understand the human factors influencing falls.
Medication	Yes	Yes	A refreshed Medicines Safety Programme is planned for 2023. Consistently reported as one of the highest reported incident categories. Focus on delayed or administration of medication.
Tissue Viability	Yes	No	This is a trust improvement priority with an established programme for change. Previous incident learning has informed this structured plan for improvement and the matters influencing tissue viability incidents is well understood. Monitoring of delivery of this trust priority will be through the patient safety governance structure. Although not proposed as a PSIRP priority for 2023-25, incidents will continue to be monitored and learning checked through periodic thematic analysis.
Admission/Discharge/ Transfer/ Transport	Yes	Yes	The challenges around the speed and complexity of discharge are recognised. One key strategic initiative is the development and implementation of a Transfer of Care Hub to better align support, signposting and completion of safe, timely discharges.
Treatment or Procedure	Yes	Yes	Deteriorating patient improvement programme informed by quality indicators and learning from reviews is underway. Further focus is required to understand contributory factors.
Clinical Assessment or Review	Yes	Yes	

			NATSSIP2 improvement project is being formed within 2023. This is informed by learning from Never Events.
Infection Control	Yes	No	National IPC improvement workstreams are in place, with embedded local and system processes for learning from healthcare associated infections (Post Infection Reviews).
Documentation	Partial	No	There is no one program which improves documentation, although the wider digital programme is a constant driver of change, with increasing digitisation of current paper records. A range of improvement work includes aspects of the timely review and ongoing quality of documentation.
Appointments	No	Yes	This is reported within the top ten most reported incidents and relates to missed, cancelled, or delayed appointments.

In reviewing the top areas of reporting, it is identified there is a similarity of theme across category types. 'Appointments', 'Admission/Discharge/Transfer/Transport' and 'Service Provision' have aspects relating to communication, handover, clinical systems and the interconnectedness of different parts of the NBT system. This is closely linked to hospital flow as a principle of right care, right time, right place. The impact of this may also not be fully recognized and can often be a contributory factor within other incident types.

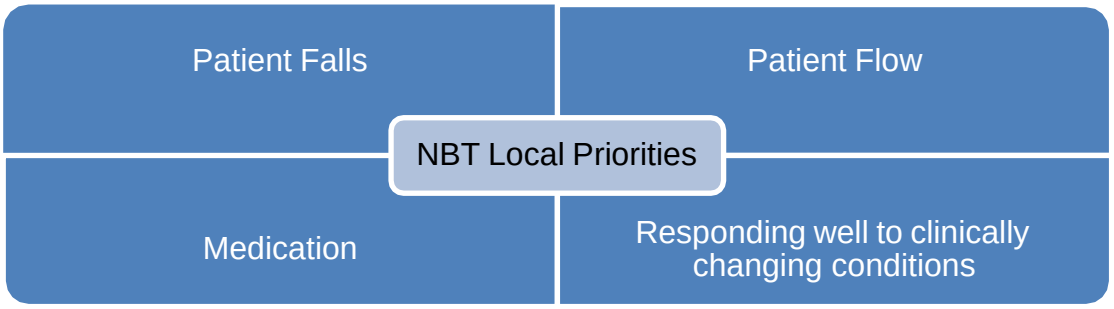
It is difficult to make meaningful connections between operational pressure and incidents due to the complexity of factors. It is possible that some reduced reporting experienced under these headings can be attributed to wider system pressures and reporting fatigue. This is not an area well understood and would benefit from applying a system thinking approach to understanding the human factors to then drive improvement.

Responding well (or deteriorating patient) can be seen as a subset of two incident types in 'Treatment or Procedure' and 'Clinical Assessment or Review'. A trust improvement workstream exists and the factors influencing a patients care or deterioration can be complex and varied, therefore understanding these requires a continued focus to ensure the change program is targeting the right areas.

Within the 'Treatment or Procedure' category also sits learning from never events concerning the implementation of the National Safety Standards for Invasive Procedures. The overall number of incidents proportionately remain low, however the impact on patients can be high. This is not recommended for a specific priority as the learning is well understood and an improvement project will seek to deliver the required changes. Whilst this is not a specific priority, this is an area that the patient safety will monitor, and proportionate decisions made on any learning response required.

For both Medication and Falls incident categories there is a significant amount of learning available however the improvement programmes are in the early stages of refresh. It is considered important to keep these incident types as a priority to ensure that current learning informs the developing improvement work.

Based on this analysis, the patient safety priorities for NBT are identified as:



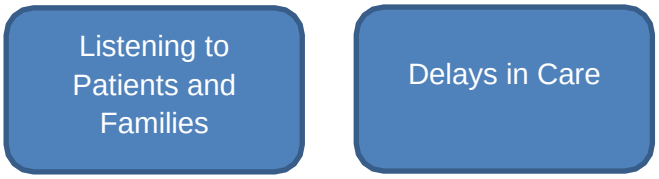
Defining our Divisional patient safety improvement profile

One of the Trust's aims is to develop tailored priorities with our 5 clinical divisions reflective of their services. In this plan the trust is commencing this approach through the development of specific improvement priorities for the Women and Childrens Division.

In understanding the profile of Women and Childrens incidents, the following have been used as sources of insight:

Improvement to Maternity and Neonatal services has and continues to be a national priority and a number of reviews, reports, audits and other external sources of recommendations and learning have been published. The Trust participates and actively contributes to the national

and external opportunities wherever possible. These provide an additional source of information. In considering these, the patient safety priorities for the Woman and Childrens Division are:



In addition, the review of insights identified that medication and responding well to clinically changing conditions (deteriorating patient) also occur as priority areas. As they align to trust level themes they are not included as separate divisional priorities. Any divisional improvement will be contributed to through trust wide programmes.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances and review by/referral to another body or team, depending on the nature of the event.

The Guide to responding proportionately to patient safety incidents defines this requirement and sets out whether mandated responses needs to be a PSII or some other response type, including referring the event to another organisation to manage.

In addition, as guidance develops and is updated, there may be times that a response type is mandated but not yet available in the current national guidance. The Patient Safety Team will track these and ensure that NBT respond appropriately. At the time of preparing this plan, the following additional mandated responses have been identified:

National Requirement	Response Required	Lead Body for Response
Blood Transfusion Incidents meeting the definition for reporting under Blood Safety and Quality Regulations (BSQR)(2005) (as amended)	PSII	NBT

Our patient safety incident response plan: local focus

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process or use other methodologies will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through a "convening authority" approach that is commonly used in the military and aviation to commission investigations and receive findings and recommendations.

Apart from the national priorities described above, the decision to carry out a patient safety incident should be based on:

- the patient safety incident is linked to one of North Bristol NHS Trust's Patient Safety Priorities that were agreed as part of the situational analysis.

- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

In understanding the methodologies available to the trust to use, we will follow those described within the Patient Safety Incident Response Framework. Within the framework MDT is identified as one option for responding to patient safety incidents. To avoid confusion with clinical MDT's that are often used as part of diagnostic or treatment decision making, NBT will refer to these as Round Table Reviews.

Our proposed approach to these priorities are:

Proposed approaches to patient safety priorities		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Trust Level		
Patient Flow	PSII or thematic review	Create local safety actions and feed these into quality improvement programmes where scope to do so has been identified
Patient Falls	Thematic Analysis or Swarm	Development of a new falls improvement programme
Medication	PSII or thematic review	Create local safety actions and feed these into trust quality improvement where possible
Responding well to clinically changing conditions	Round Table Review or PSII	Continuation and evolution of the deteriorating patient workstream

Proposed approaches to patient safety priorities specific to Women and Children's Health		
Listening to Patients and Families	After Action Review, Swarm or Round Table Review Complaints investigation and response and/or Local resolution meetings	Learning will be reviewed and channelled into the three-year delivery plan improvement work.
Delays in Care	After Action Review, Swarm or Round Table Review	Create local safety actions and feed these into Divisional quality improvement where possible

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 26-30 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

To deliver these investigations we will use existing structures to support the process of decision making. For trust level and national priorities, an established weekly meeting with the Chief Nursing Officer and Chief Medical Officer, in which potential incidents and other emerging patient safety issues are discussed, will make agreements made on the most proportionate response. Responsibility for identification of incidents in scope of a PSII and any investigation will be sourced from within Divisions or leads for improvement programmes.

For Divisional led priorities, the Woman and Childrens Divisional Governance team will have oversight of commissioning, investigation, and approval of these investigations which fall within scope of their services. Approvals will be granted through their Divisional Management Team. Oversight of learning, trends and themes will be taken to the trust wide Patient Safety Committee.

As PSIRF is a new way of responding to incidents and uses new investigation models for in-depth investigations, the trust is on a continuous journey to develop new tools for understanding why incidents happen. To support Divisions, the central Patient Safety Team will provide expertise, advice, and guidance to enable a consistent application of this plan.

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

As part of our policy framework, we will continue to develop our practice and procedures to support staff in how to work with patients and family as part of responding to patient safety incidents.

In some cases, incidents will meet the statutory duty of candour thresholds. There is no legal duty to investigate a patient safety incident. However, once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

Involvement and support for staff following incidents

We are on an ambitious journey at the Trust to ensure it is a safe and fair place, where everyone’s voice is encouraged, valued, and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a wealth of excellent psychological wellbeing support for all staff with information available through our staff intranet pages.

Our patient safety incident pro-active plan: local focus

Patient Safety can be focussed on learning from things that have already happened, however the move to PSIRF encourages a more systematic consideration of the risks presented to delivering healthcare to patients. At NBT we want to stretch ourselves to focus on how we can utilise proactive patient safety to anticipate and prevent problems before they occur.

Our plan to achieve proactive patient safety focusses around a number of priorities:

Patient Safety Culture: this priority has three main aspects, all centred around making sure our staff are empowered to speak up, feel safe, and can make changes within areas of their control.

Through adopting a ‘just culture’ and creating psychological safety, we can support our staff to be more resilient, achieve better levels of communication, create an openness to learning, improve performance, and influence positive attitudes.

The benefit to patient safety is that this creates an environment for our staff which is based on respect, honesty and open dialogue. This is especially important when incidents occur and is a foundation to the reflective practice our staff undertaken when understanding what happened. No one comes to work to get in trouble or sanctioned because something has gone wrong, a just culture enables us to view things in a different way without blame or fear of consequence. Ultimately this is about building trust between peers, teams and the organisation which directly impacts how we perform and achieves better outcomes for our patients.

To achieve this we will undertake activities across the year to support us in gaining insights to our culture. This may be through looking at triangulating themes across different parts of NBT, such as our staff survey results and Freedom to Speak Up. We will also engage our teams directly using national patient safety tools to support understanding our culture, staff and team awareness and inform changes where improvement is needed.

Patient Safety Governance: Our governance mechanisms at Trust level and the interfaces with clinical divisions are being re-evaluated as part of the refresh of the PSIRP and in light of the Trust’s Strategy and Patient First approach. Existing governance mechanisms for proactively reviewing incidents and other intelligence in relation to safe and harm free care continue whilst this evolves, with primary workstreams being:

- Patient Falls
- Pressure Injuries
- Infection Prevention & Control
- Medication Safety
- Identifying and responding to deterioration of patients’ clinical condition
- VTE prevention & response
- Safe Maternity Care – which extends into the wide range of proactive and measures covered through the Perinatal Mortality Surveillance tool
- Learning From Deaths – including through Medical Examiner concerns/referrals and Structured Judgment Reviews

As part of our continued refinement to our approach to the Patient Safety Incident Reporting Framework (PSIRF), we are considering the interrelationships between different risks of harm and how we take a more holistic way of approaching continuous improvement to identify and respond to areas of learning before incidents occur. It is our intention to bring individual workstreams and assurance processes that already exist into a combined programme of work, with stronger governance and improvement oversight.

Health Inequalities: understanding how NBT’s services impact different people is important in minimising harm and reducing variation in patient outcomes. As we take this plan forward, we will explore if and how those within protected characteristics are kept safe, and to proactively consider their needs within the design of care pathways.

In addition, as we increasingly seek to empower people to be active in their own healthcare, and within patient safety to understand how incidents occurred, there is a need for the Trust to build on how we support those with specific needs. Aligned with our Patient and Carer

Experience Strategy we will create opportunities for those from diverse backgrounds to be involved as Patient Safety Partners.

Generative leadership: linked to culture within our organisation is the role of leaders. We will build on the work that leaders are already undertaking to ensure ward to board connectivity, and presence to demonstrate support to safe care. Generative leadership is not just about adapting but being creative, and empowering people to be engaged in change and not just observing others apply it to them.

An example of where we have already made this happen already is using safety champions within the Woman and Childrens Division. These champions are a mix of senior staff and the clinical team, along with the Non-Executive Director with responsibility for Maternity Services, the Chief Nurse, and Head of Patient Safety. In fulfilling this role, the group engage directly with the service through a programme of walk arounds focussed on patient safety where they talk to staff and patients and observe the environment around them. These observations are then distilled into points of good practice or actions which the division take forward to make improvement.

Development of Human Factors knowledge and Skills: Through supporting staff to be curious and speak up we need to enable them to view opportunities for change through the right lens. Human factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, human factors offer ways to minimise and mitigate human frailties, thereby creating consistent delivery of care. We will develop training and resources to provide individuals with the skills they need to consider human factors in their everyday work to inform quality improvement in teams and services, support change management, and help to emphasise the importance of the design of equipment, processes, procedures, and care.

Implementation and development of the national Learning from Patient Safety Events: NHSE are implementing a new way of nationally capturing incident information and requires organisations to collect certain types of data. Within this are specific asks which will enable the Trust to consider a proactive response through identification of incidents that have not yet affected patients, and a greater emphasis on identification of risks.

This is one part of how we use data to our advantage and understand the risks to patient safety. We will develop ways that draw combined data on the quality and performance of services to triangulate learning and take action to prevent harm occurring to patients. For example, the trust has recently developed a triangulation group which brings our people team, freedom to speak up, patient safety, safeguarding, health and safety and our PALS & Complaints team together to understand what is affecting the safety of patients and staff.

Recognising when things go well: Much of patient safety is responding after incidents have occurred and understanding why something has gone wrong. In further developing our patient safety practice linked to the national implementation of the Patient Safety Incident Response Framework, we will develop ways to explore examples of how our teams provide outstanding care. Utilising principles such as appreciative enquiry we will focus on strengths, successes, and opportunities rather than solely on identifying weaknesses and problems. Through understanding what enables our teams to provide the best care possible, we can then spread that to other parts of our organisatio