September 2023

East and North Hertfordshire NHS Trust

Patient safety incident response plan

Effective date: September 2023

Estimated refresh date: September 2024

	Name	Title	Signature	Date
Authors	Margaret Mary Devaney	Director of Quality and Patient Safety Specialist		June 23
	Jon Bramall	Consultant Anaesthetist and Intensivist		June 23
		Associate Medical Director for Quality and Patient Safety		
	Tracey Van Wyk	Head of Quality Improvement		June 23
Reviewer	Michelle Anstiss	Associate Director of Governance		June 23
	Chris Curtis	Patient Safety Partner		June 23
Authoriser	Quality and Safety Committee			28 June 23
	Trust Board			5 July 23

V5.5 Final

Contents

Foreword from our Director of Quality 4
Introduction 5
Our services 6
About the Trust 6
Organisational Structure 7
Strategy overview and objectives 7
Safety Culture 8
Involvement and support for staff following incidents 8
Involvement of patients, families and carers following incidents 9
Defining our patient safety incident profile 9
Defining our patient safety improvement profile 11
PSIRF training requirements at ENHT 14
Patient safety improvement programme 15
Our patient safety incident response plan: national requirements 16
Responding to cross-system incidents/issues 19
Learning Responses from Good Care 19
Our patient safety incident response plan: local focus 20
Appendix A ENHT Improvement programmes 2023/2024 21
Appendix B List of abbreviations 25

Foreword from our Director of Quality

For anyone who has been exposed to the systems, processes and cultural challenges of improving patient safety, then like me, they will welcome the proposed changes within the new Patient Safety Incident Response Framework (PSIRF).

The current approaches to patient safety can be top down, target driven and bureaucratic. They have, for a long time been focussed on collecting data and often fail to support sustainable improvements.

Changes within the new PSIRF plan will embrace the opportunity to produce a learning framework that builds on the ethos that humans are fallible and improvements can only be achieved through systematic changes that are co-designed. Sustainable improvements will only be possible through a multidisciplinary approach and a true value placed on understanding what matters to patients and families.

The Trust values support the approach to include, respect and improve as the basis for how we work. Staff will be supported when they are involved in an error and be encouraged to speak up about any concerns, they have around the safety of the service they deliver.

This plan will aim to close the gap on the theory of delivering safe care 'and the reality' of delivering safe care.

When an error occurs we can often over simplify a solution to prevent it happening again, where we have missed the opportunity to explore complicated and complex problems that require a different approach for learning to take place, and in tandem a different approach to improve. Improving safety may require a combination of actions that affect clinical practice, organisational processes, information management, tools and equipment, communication methods, external factors, and individual person human factors. Therefore, how we respond and learn when an incident occurs requires a more holistic approach to drive sustained improvements.

Relationships are at the heart of the PSIRF plan. Providing 'psychological safety' when we are at work enables people to feel safe when they make a mistake, confident to ask for help and helps produce a more effective, high performing team.

'*What we do know is that there is an observed correlation between psychological safety and learning and performance'*

Edmondson 2019

Margaret Mary Devaney

RGN, Director of Quality

Introduction

The NHS Patient Safety Strategy was published in 2019 with some key objectives to transform how patient safety is manged in healthcare. One key objective was to establish a new improvement focused Patient Safety Incident Response Framework (PSIRF) with the purpose of learning and improving patient safety.

This patient safety incident response plan sets out how East and North Hertfordshire NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months.

The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

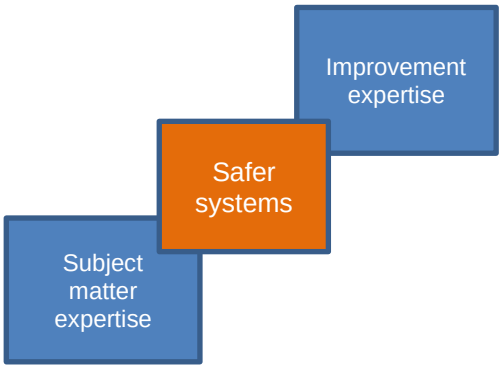
It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

1. compassionate engagement and involvement of those affected by patient safety
2. application of a range of system-based approaches to learning from patient safety incidents
3. considered and proportionate responses to patient safety incidents
4. supportive oversight focused on strengthening response system functioning and improvement.

Preparation for this change has been occurring nationally through some early adopter sites, but some local changes have also been happening here that lend us to transition to this new way of working.

Through the current serious incident framework management, we have started to ‘cluster’ similar incidents together to support more collaborative learning and changes. We have adopted multidisciplinary ‘round table’ learning forums where staff can share their knowledge and experiences of the incident that has occurred.

We have been following a structured approach to improving safety through improvement collaboratives such as ‘harm free care’, ‘sepsis’ and ‘deteriorating patient collaborative’, combining the expertise of patent safety and improvement science.



This PSIRF plan has been produced following interrogation of information across ENHT services, collating patients’ and family experience and asking staff what response they

need when an error occurs. Our Patient Safety Partner has been involved in the production of our plan. We intend to continue wider stakeholder engagement with ICB and system colleagues, HM Coroner and local authority colleagues.

Our services

About the Trust

East and North Hertfordshire NHS Trust was created in April 2000, following the merger of two former NHS Trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and tertiary care services from four hospitals, namely: the Lister in Stevenage; the New Queen Elizabeth Hospital II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, within the London Borough of Hillingdon.

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, which was commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened fully from June 2015 and provides outpatient, diagnostic and antenatal services, along with an urgent care centre. Hertford County also provides outpatient and diagnostic services. The Mount Vernon cancer centre provides tertiary cancer services including radiotherapy, chemotherapy and immunology services.

The Trust owns the freehold for each of the Lister and Hertford County; the New QEII is operated on behalf of the NHS by Community Health Partnerships and the Mount Vernon Cancer centre operates out of facilities owned by the Hillingdon Hospitals NHS Foundation Trust.

The area served by the Trust for acute hospital care covers a population of just over 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some three million people from across Hertfordshire, Bedfordshire, Luton, north-west London and parts of the Thames Valley. The Trust's main catchment is a mixture of urban and rural areas that are in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City. From 2018 to mid-2021, the Trust saw a consistent reduction in mortality, with rates that were consistently lower than our national peers. While the last eighteen months have seen an upward trend, this has been mirrored nationally, the Trust remains well positioned compared to national peers.

The birth rate is slightly lower than the England average, with the Trust's core catchment population forecast to rise by approximately 6% in the years to 2030; the most significant growth is expected in people aged 65 and over (25%) with this age group also more likely to have the greatest impact in terms of health needs. Black and minority ethnic groups (i.e. non-white British) make up approximately 10% of the population in east and north Hertfordshire. In addition, it is expected that just under 17,000 new houses are planned to be built in the Trust's core catchment area by 2030.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 6,750 staff are employed by the Trust. The Trust's annual turnover is approximately £610.6 million.

Organisational Structure

During the year, the Trust moved to a clinical operational structure of four Divisions consisting of Planned Care; Unplanned Care; Women's and Children; and Cancer. Prior to this the Trust had two operational Divisions: Planned Care, and Unplanned Care.

Supporting the clinical divisions are corporate teams covering areas including: finance and planning, digital; medical practice, education and research; nursing practice; strategy; estates and facilities; transformation, and workforce and organisational development.

Strategy overview and objectives

The Trust's Vision is "To be trusted to provide consistently outstanding care and exemplary service".

The Trust has four guiding themes that shape its annual objectives:

- **Quality** – Consistently deliver quality standards, targeting health inequalities and involving patients in their care

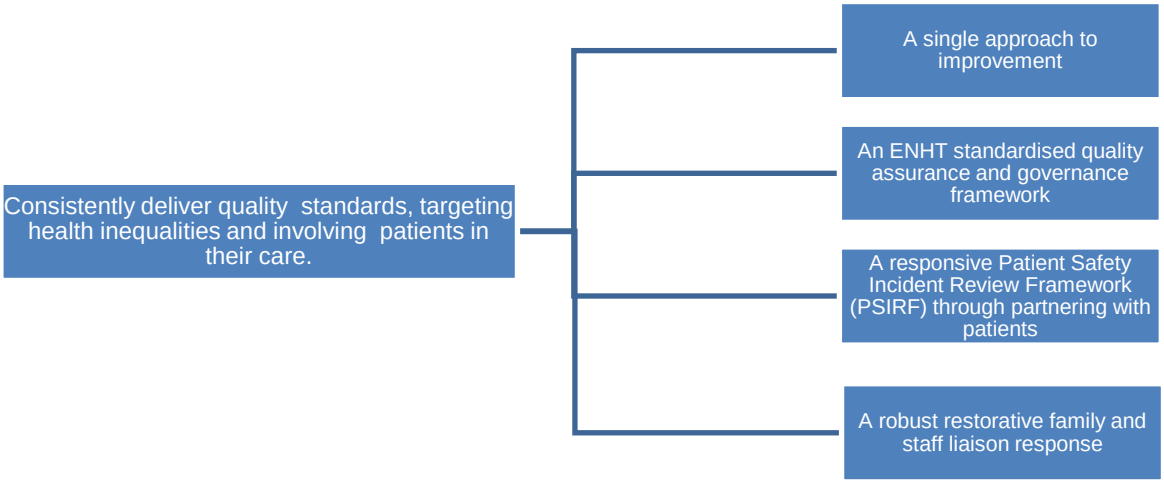
- **Thriving People** – Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy and accountability

- **Seamless Services** – Deliver seamless care for patients through effective collaboration and coordination of services within the Trust and with our partners

- **Continuous Improvement** – Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

These themes and objectives are underpinned by our Trust Values: Include, Respect and Improve.

The Trust launched its five year Quality Strategy in 2019. Key quality strategy drivers for 2023/24 include:



Safety Culture

We are in the process of defining our safety culture and work is underway, involving a wide range of multi-disciplinary staff (including HR & OD colleagues, clinical leaders, and Freedom to Speak Up Guardian) to:

- Interview staff involved in various incident and HR investigations to understand their experiences to inform improvements and culture change where required

- Review and revise HR policies to ensure they do not undermine just culture through sanctions or suspensions and that they reflect a restorative and just culture approach

The Trust recognises the importance of Freedom to Speak Up and that it is crucial to encourage a positive culture where people feel they can speak up without fear and their voices will be heard, and result in meaningful actions. The Speaking Up policy ensures that all our staff (including permanent employees, agency staff, students, contractors and volunteers) have a voice that counts. It enables staff to feel safe and confident to speak up through a variety of methods. It advocates that at ENHT the time is taken to really listen to understand the hopes and fears that lie behind the words. It supports us to build a culture and behaviours that is responsive to feedback from workers

Involvement and support for staff following incidents

We are on a journey at ENHT 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.

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 range of wellbeing support for staff which will be explicit in our new policy framework.

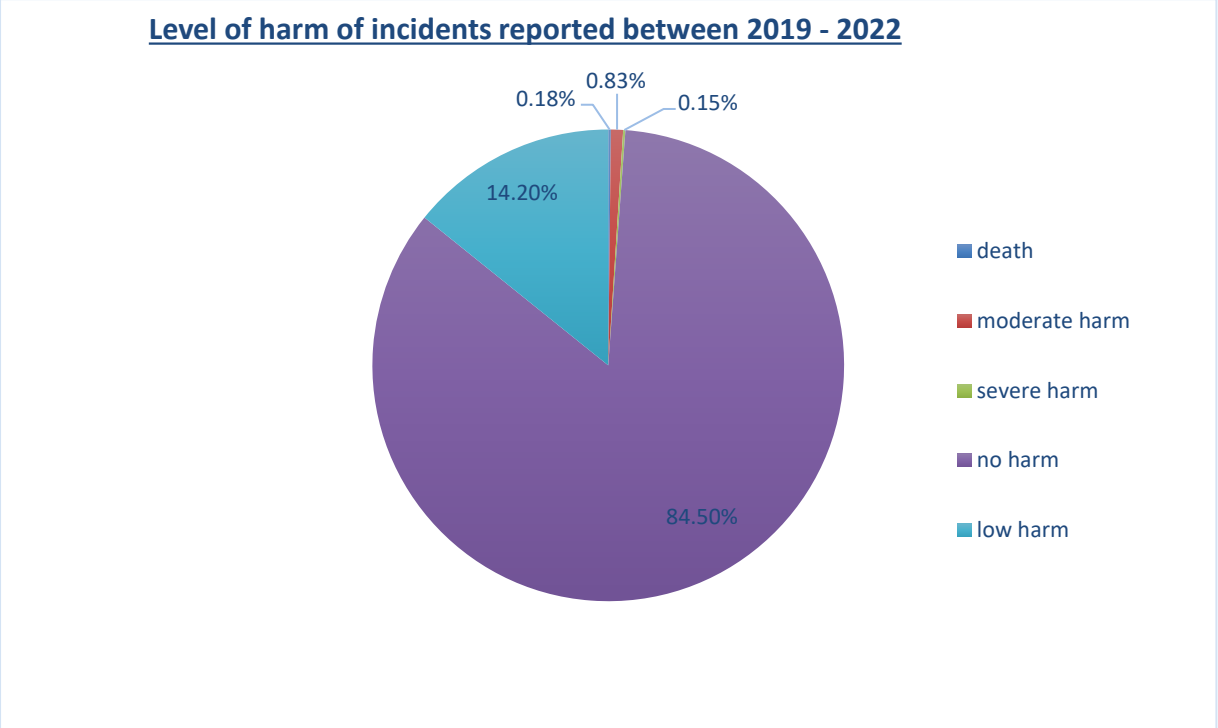
We will be formalising our policy framework throughout the autumn of 2023, which will provide detailed guidance for staff involved in safety incidents, to support this plan.

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 improvements to the services we provide. The patient voice is very much an integral part of our work at ENHT and as part of our new policy framework, with involvement from our Patient Safety Partner, we will be developing procedures and guidance to support staff in how to discuss incidents and involve patients and families.

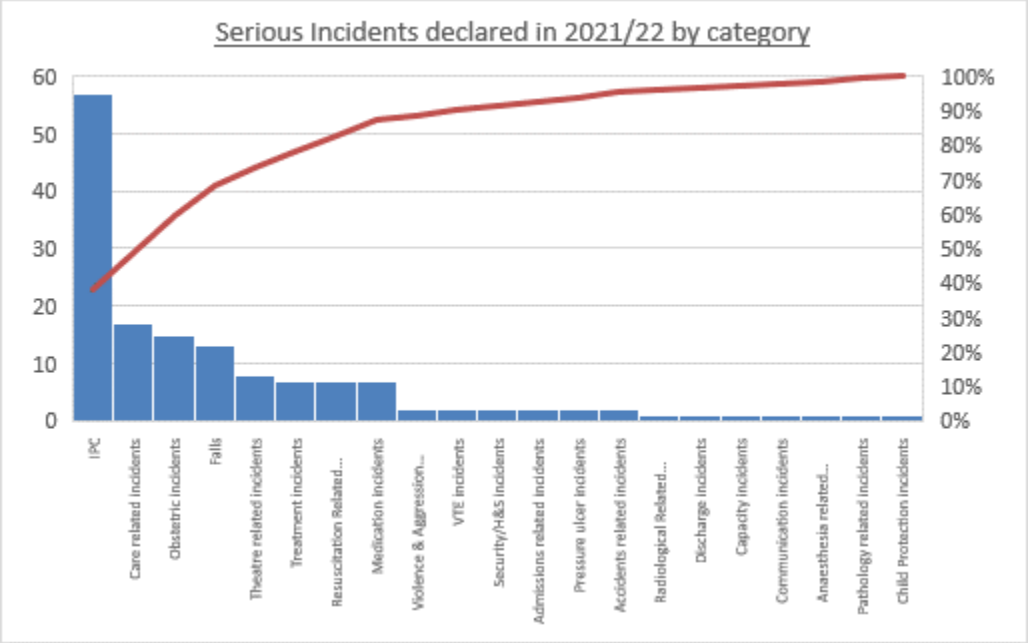
Defining our patient safety incident profile

Between 1 April 2019 and 31 March 2022, 48,166 incidents were reported. Of these, 98% resulted in no or low harm. The chart shows a breakdown of the incidents by harm.



Of the Serious Incidents declared during the financial year 2021/22, the largest category was infection control incidents relating to healthcare acquired hospital onset COVID-19.

Of the remaining incidents the key themes were related to care, obstetric incidents, falls, treatment incidents and medication incidents which is in line with previous years.



Data was also examined from claims where the key themes were related to failures and delays in diagnosis and treatment, as well as recognised complications of surgical procedures.

Complaints and concerns were also analysed and the top themes were communication, medical care, diagnosis, discharges, and delayed treatment and care.

In analysing the data it was important to bear in mind that neither the crude number of incidents nor the level of harm is the best predictor of what should be the Trust's patient safety priorities. For example, 'falls' features in the list of incidents and is also associated with harm, and yet the benchmarking data shows that the harm associated with falls is similar to other trusts. Of course, work minimising the risk of falls will continue, but other areas should form the main priorities for the Trust.

A wide variety of stakeholders were engaged in analysing the data and developing the patient safety priorities. This group included teams involved in incident investigation, claims, complaints, and risk. There was engagement with mortality surveillance, pharmacy and the Quality Improvement team. The team also included a patient representative.

A significant theme that emerged was around the culture surrounding patient safety incidents, as well as the broader culture in the organisation. Learning has highlighted that some current responses to incidents can appear punitive, uncivil and unappreciative of the impact on staff. For this reason, "improving safety communication through building a culture of safety and co-production" was included as a priority.

Five general themes were identified which allows scope for more specific investigations within these areas. The themes span across all divisions in the Trust. These initial investigations and improvement work may be then transferrable to other areas within that domain.

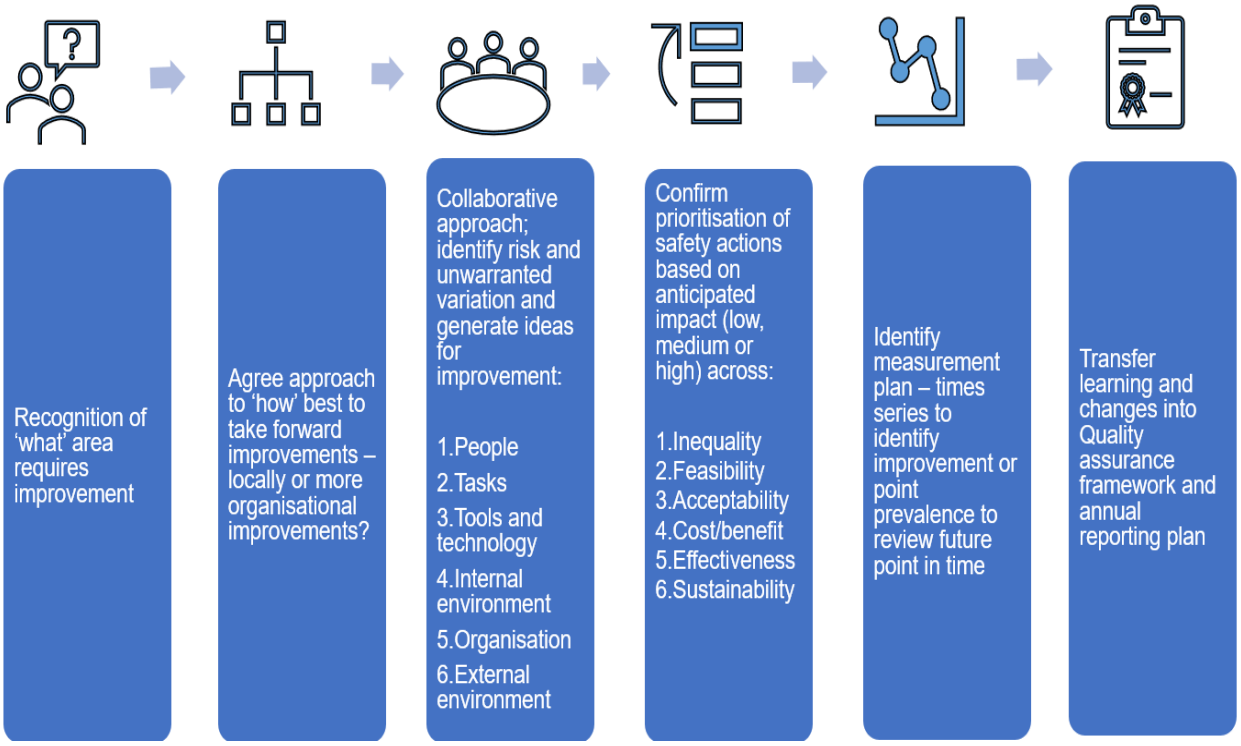
Patient Safety Priority	Rationale	Suggested initial focus for PSII / Improvement
Improving safety communication through building a culture of safety and co-production	Communication failures was a common theme throughout incidents, complaints and claims. This priority will impact on the improvement work for all other priorities	Civility and culture
Early recognition, reliability and managing acutely unwell/deteriorating patient	Serious incidents reports and claims have shown that this is a significant problem and current performance data shows that it remains a current issue	Early recognition, and prompt response to deterioration
Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors and Venous thromboembolism (VTE)	The Harm Free Care programme has been running some improvement work in these areas. Data shows that it continues to be an issue that matters.	Reducing medication incidents
Recognition and management of challenging behaviours/ Violence and aggression	There has been an increasing number of incidents relating to the management of challenging behaviour.	Mental health crises in acute hospital
Reducing patient safety risks from long waiting times from admission to discharge	There have been incidents related to patients on waiting lists as well as process delays during inpatient stay. This priority has some significant risk register entries associated with it	Delays in care in Ophthalmology, Paediatric audiology and Breast services

Defining our patient safety improvement profile

The following principles will apply to our patient safety improvement programme:

- Improvement will be co-design and co-delivery with staff, patients, carers and the public
- The Trust will support being courageous and providing the leadership necessary to make change happen
- We will continue to deliver good quality health and social care services whilst we make changes
- Changing to a true partnership approach with a culture of shared innovation and learning with our patients
- Building upon best practice and utilising work already undertaken such as harm free care collaborative and transformation programmes
- Working collaboratively with others where services operate across boundaries

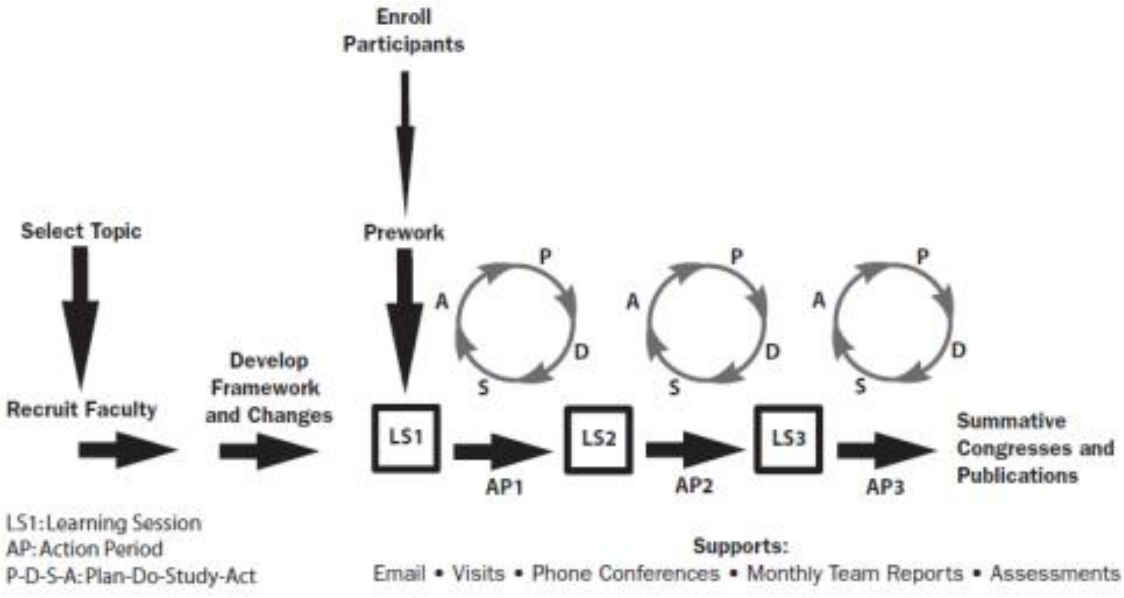
Learning from incidents shall inform our patient safety improvement programmes. The safety learning pathway shall follow key point below:



On occasions, an incident type may already be well understood. For example, a previous similar incident may already have been investigated with improvement plans to address the causes implemented along with effective monitoring. In this scenario, resources may be better directed at improvement rather than repeating an investigation that will yield the same outcome.

Opportunities exist across ENHT internal and external systems to learn through a structured and collaborative 'Series Collaborative Model' (2003), detailed in the diagram below:

Figure 2. Breakthrough Series Model



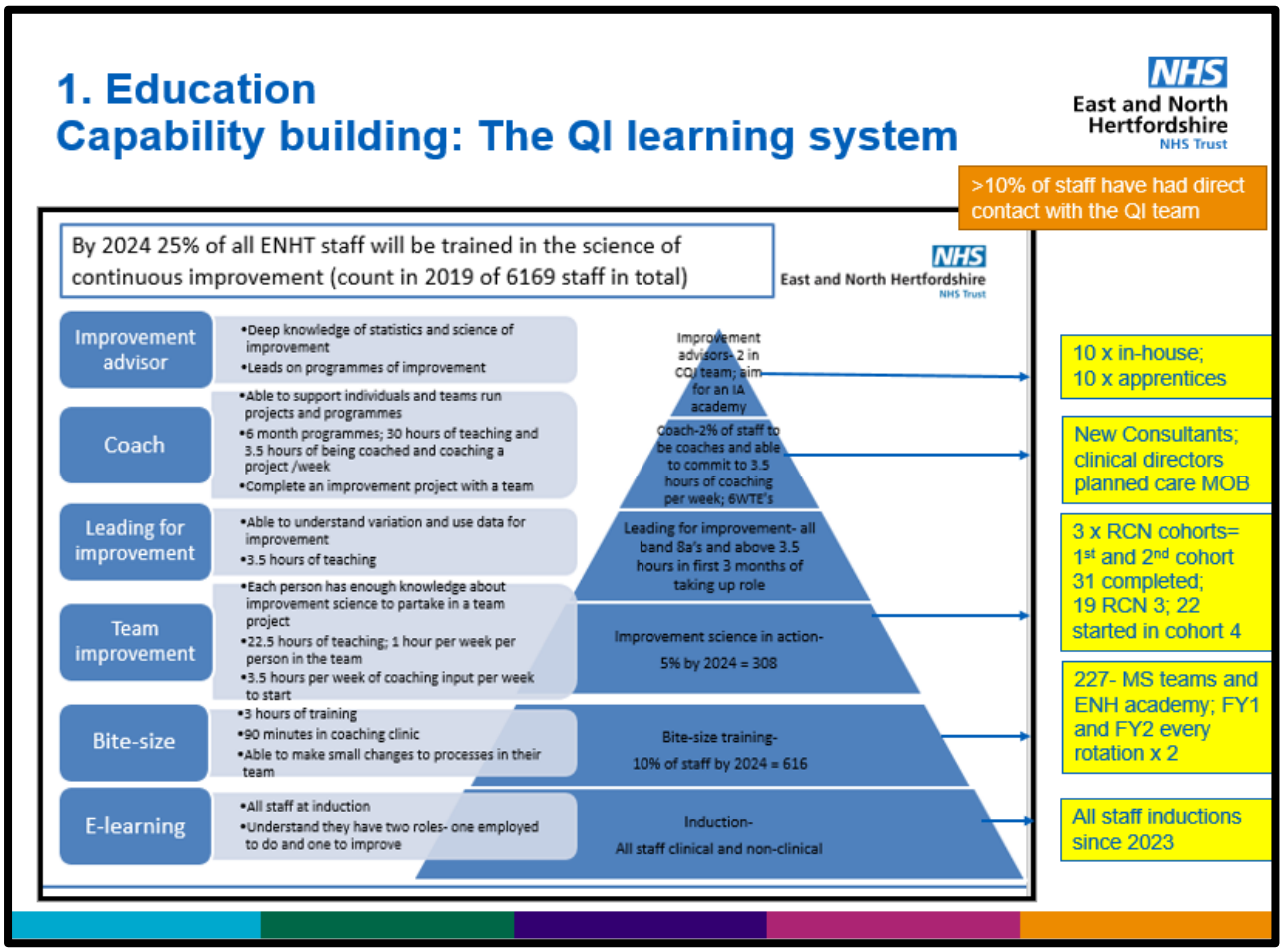
At ENHT we want to engage with our patients in new ways that enhance the quality of care and improve the patient experience. We have successfully involved patients with our Continuous Quality Improvement co-design programmes, and we have recruited our first Patient Safety Partner (PSP). The PSP is committed to co-designing how we continue to work with patients, their families and carers, and staff to identify what patients need and want. This will help us to understand the role that patients can play in their own safety, and the different mechanisms that could work to help them be informed and safe.

Alongside work on safety and prevention, we will be actively promoting and encouraging the Duty of Candour. At the same time, we will be working to create a more informed process for patients and families around incidents and future learning reviews.

Training and development for safety improvement

The Trust has delivered a programme of building improvement skills through:

- **Programmes**: harm free care and deteriorating patients.
- **Projects:** 57
- **Coaching:** 178 people have attended running programmes, projects and training and coaching.
- **Training:** Over 300 trained at varying levels of depth of knowledge.



The Trust plans to increase the understanding of improvement skills, patient safety and develop a safety culture together with human factors by completing the following:

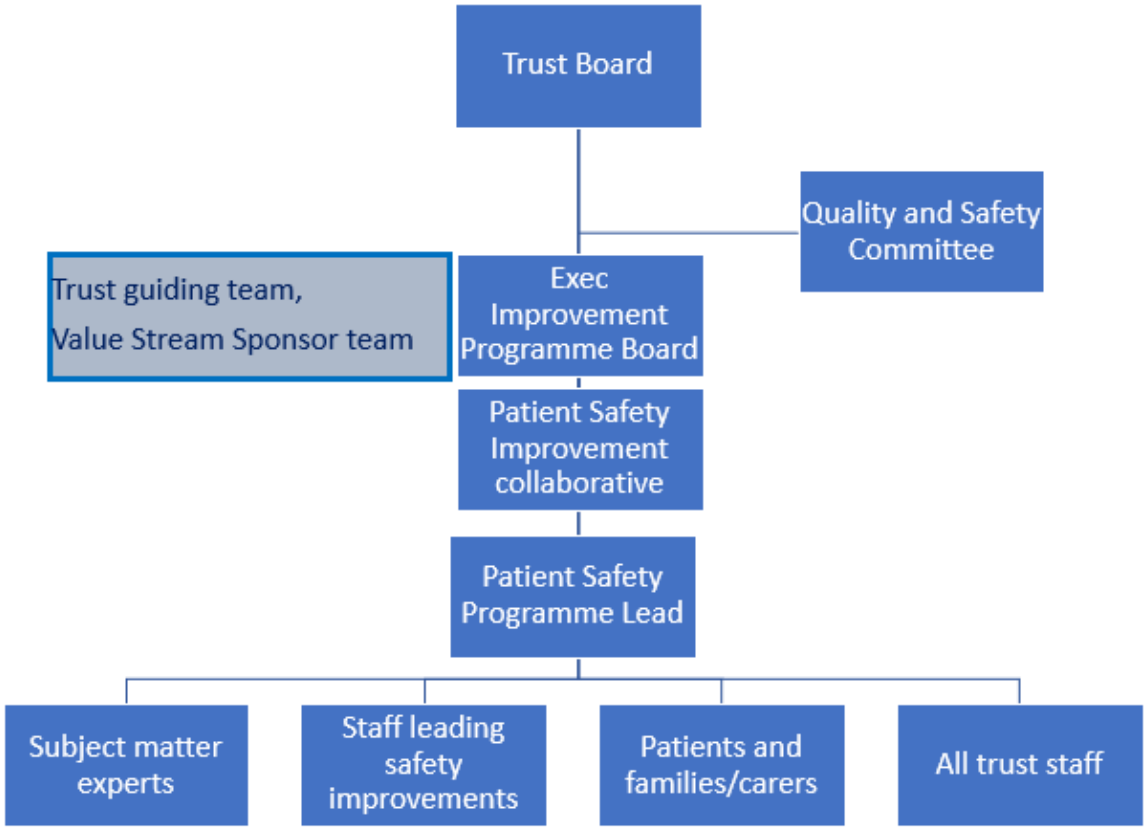
- develop Continuous Quality Improvement (CQI) training strategy in partnership with Virginia Mason Institute
- develop Board skills and understanding in CQI
- set up a Quality Improvement faculty and steering group
- identify human factors training opportunities
- provide opportunities for undergraduate and postgraduate multi-disciplinary CQI development
- implement suite of learning responses that will inform improvement efforts e.g. facilitated debriefs (after action reviews), SWARMs, walk through, talk through, and other response skills
- provide expanded online CQI and safety science (SEIPS) resources
- support staff to become patient safety improvement leaders
- support the development and deployment of Patient Safety Partners

PSIRF training requirements at ENHT

Training	**Summary and audience**	**Duration**	**Provider and Expected Staff Numbers**
Essentials of patient safety for all staff	Level 1: All staff (priority those in engagement, learning response and oversight roles)	30-60mins	eLearning for health (ENH Academy) 6000+
Essentials of patient safety	Level 1: Essentials of patient safety for boards and senior leadership team (oversight roles)	30-60mins	eLearning for health (ENH Academy)
Essentials of patient safety L2	Level 2: Access to Practice (Learning Response Leads) There are two sessions. The first introduces *systems thinking,* the second session looks at *human factors* (the science of work and of working together in safely designed systems) and *safety culture* (the significance of a true learning culture, free of inappropriate blame)	30-60mins	eLearning for health (ENH Academy) All medical staff and AfC staff band 5 and above
Systems approach to learning from patient safety incidents	*(Required for learning response leads and those in oversight roles)*	2 days	Initially external provider and review in-house capacity and capability to deliver going forward
Oversight of learning from patient safety incidents oversight	*(Required for those in oversight roles)*	1 day	Initially external provider and review in-house capacity and capability going forward.

Additional Training available according to Training Needs Analysis (TNA)			
Multidisciplinary team (MDT) review/round tables			
Swarm huddle/Hot debrief/safety huddle			
After action review (AAR)			
Facilitation skills and confidence building to run MDTs, roundtables, SWARMs, hot debriefs, group facilitation, facilitating improvement planning			
Schwartz rounds – conversation alongside the Trust approach			
Additional training – adhoc short external courses as required			
Patient and staff involvement in learning from patient safety incidents	*(Required for engagement leads and those in oversight roles)*	1 day	Initially external provider and review in-house capacity and capability to deliver going forward

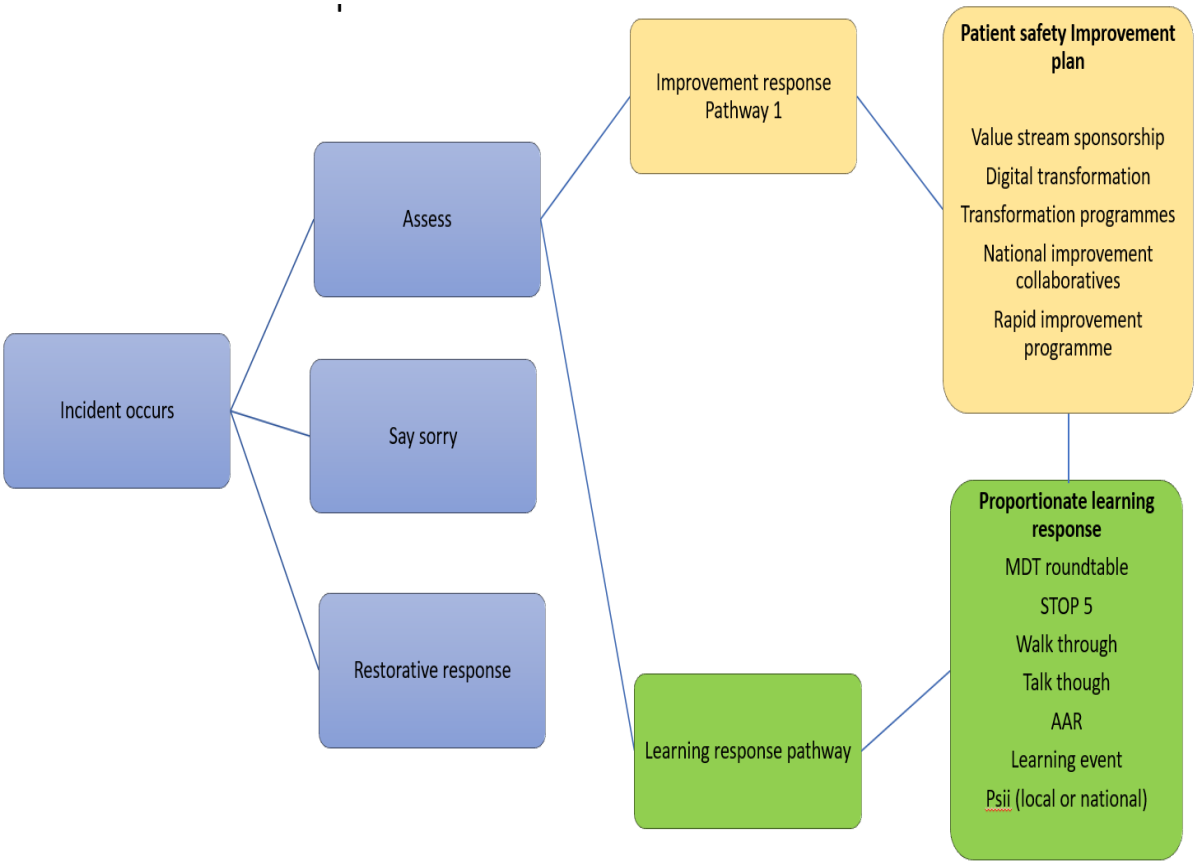
Patient safety improvement programme



Our patient safety incident response plan: national requirements

The aim is to achieve a systematic learning and improvement approach and less of a ‘cause and effect’ approach, through recognising that multiple interactions and contributory factors exist across a ‘whole system’.

Learning shall be achieved through adoption of tools that explore interacting contributory factors rather than a single factor. Research has demonstrated that the learning should scope Systems Engineering Initiative for Patient Safety (SEIPS) 6 key factors i.e. person (s), tasks, tools and technology, internal environment, organisation and external environment. When these areas are considered together they will support insight to all elements of our ‘systems’.



Some events in healthcare require a specific type of response as set out in policies or regulations. These responses may include mandatory Patient Safety Incident Investigation (PSII), review by or referral to another body or team, depending on the nature of the event.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 10 PSII reviews per annum where national requirements have been met.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the safety improvement plan
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Create local organisational actions and feed these into the safety improvement plan
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and feed these into the safety improvement plan
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	Respond to recommendations as required and feed actions into the safety improvement plan
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and feed actions into the safety improvement plan
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may	Respond to recommendations as required and feed actions into the safety improvement

	be required alongside the LeDeR – organisations should liaise with this	plan
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Respond to recommendations as required and feed actions into the safety improvement plan
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	Respond to recommendations as required and feed actions into the safety improvement plan
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of	Respond to recommendations as required and feed actions into the safety improvement plan

	the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	

Responding to cross-system incidents/issues

The Trust will work with other NHS Trusts, relevant system care providers and stakeholders and ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Where it is recognised that an incident requires a cross-system learning response, it will be escalated to the Trust Safety Oversight Panel (currently SIRP) from the Divisional Safety Oversight Panel (Currently Quality and Safety/Governance groups) and/or escalations from external sources to the Trust.

The Trust will proactively seek out learning opportunities eg with other providers, GPs, the local authority, Police and Ambulance Service. Further detail is included in our policy.

Learning Responses from Good Care

Learning from good or positive care will be reported on the Trust's Quality Management System, ENHance as a 'good care' event in line with LFPSE reporting. These will be reviewed through Divisional Oversight Meetings to ensure that where appropriate, the relevant learning responses are undertaken and the findings shared across teams in order to maximise learning.

Information from the Quality Management System will be analysed to understand themes and trends across the system and this will be incorporated into the regular incident and compliance reporting.

Our patient safety incident response plan: local focus

ENHT shall continue explore patient safety incidents relevant to the population we serve rather than exploring only those that meet a certain nationally defined threshold.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Improving safety communication through building a culture of safety and co-production	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Early recognition, reliability and managing acutely unwell/deteriorating patient	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors and VTE	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Recognition and management of challenging behaviours/ Violence and aggression	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Reducing patient safety risks from long waiting times from admission to discharge	Learning response pathway	Create local safety actions and feed these into the safety improvement plan

We have provided a list of current improvement work underway at ENHT (Appendix A). We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types, either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required, where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Appendix A - ENHT Improvement programmes 2023/2024

Existing work stream/project	PSIRF Plan local theme
Deteriorating patients including reliability of observations, escalations and human factors SIM training after events.	Early recognition, reliability and managing acutely unwell/deteriorating patient.
Harm free care programme including the prevention of VTE, falls, medication errors, CAUTI, IPC poor nutrition and hydration and pressure ulcers.	Reducing avoidable harm for pressure ulcers, critical medications, falls, CAUTI and IPC, nutrition, medication errors and VTE.
RCN clinical leadership programme- 20 leaders in each cohort lead a project that aligns to a safety and or an experience priority for their team.	Could cover any one of the themes if focusing on safety.
Keeping our patients safe digital transformation project Digital transformation programme.	Early recognition, reliability and managing acutely unwell/deteriorating patients. Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors and VTE. Recognition and management of challenging behaviours/ Violence and aggression.
Maternity improvement programme.	Maternity safety priorities including national patient safety initiatives.
Mount Vernon cancer centre re-provision programme board.	Re-provisioning of pathways.
Transformation programmes: a. Care closer to home b. Temporary workforce c. Fundamentals of care and pathways to excellence d. Urgent and emergency care e. Surgical pathways f. Community diagnostic centre programme g. Outpatient department programme including patient initiated follow-up h. Criteria lead discharge programmes i. Complaints j. Hospital at home	Different programme streams touch on each of the five different local safety themes.

Appendix B - List of abbreviations frequently used throughout the document

Acronym	Meaning
AAR	After action review
AfC	Agenda of Change
DOC	Duty of Candour
DSIRP	Divisional Safety Incident Response
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPO	Kaizen Promotion Office
LFPSE	Learning from patient safety event
MDT	Multi-disciplinary Team
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety
PSP	Patient Safety Partner
QM	Quality Management
RJLC	restorative, just and learning culture
SIRP	Safety Incident Response Panel
SOP	Standard Operating Procedure
TEL	Technology Enhanced Learning
VMI	Virginia Mason Institute