Patient Safety Incident Response Plan

Effective date: April 2025

Estimated refresh date: October 2026

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Ratifying Group	**Policy Review Group**		**23 April 2025**

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Introduction

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This patient safety incident response plan (PSIRP) sets out how Warrington and Halton Teaching Hospital and NHS Trust (WHH) intends to respond to patient safety incidents over a period of 18 months. The plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on Duty of Candour and the revised Trust patient safety incident response policy.

Following review of progress in terms of embedding learning and improvement and scrutinising the data 2023-24, reports presented via the Trust Governance structure the decision was taken in consultation with colleagues that we would continue with the same local priorities through the next phase of PSIRFF to enable robust sustained learning and improvement.

A glossary of terms used can be found at Appendix A

Our services

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) provides services to a population of approximately 330,000 living in and around Warrington and Halton boroughs. The demographic of the area shows most people are born in England and there are a small percentage of people from other nationalities.

Warrington and Halton Teaching Hospitals NHS Foundation Trust provides acute care from Warrington Hospital in Warrington and the Halton Hospital Nightingale building in Runcorn, alongside the Halton Hospital Captain Sir Tom Moore Building the home of the breast care centre and surgery.

Warrington Hospital was formed in 1898 and merged with Halton Hospital in April 2001 to become North Cheshire Hospitals NHS Foundation Trust. Before becoming Warrington and Halton Hospitals NHS Foundation Trust on 1 December 2008.

The Trust has a total of 668 beds across all three sites: acute care inpatient, day case and specialist beds at Warrington, elective surgical beds, and intermediate care beds at Halton Hospital Nightingale Building and Halton Hospital Captain Sir Tom Moore Building for surgery.

WHH employs more than 5,000 staff from over 50 nationalities, many who live in the boroughs we serve and provide a range of services such as urgent and emergency care, maternity, surgery, outpatients, therapies, and children's health. On average 3000 babies are born at Warrington Hospital each year.

Defining our patient safety incident profile

The Trust has a commitment to continuously learning from patient safety incidents and has developed an understanding and insights into patient safety matters over a period of years. WHH have weekly Executive-led Safety Oversight Meetings (SOM), and monthly Executive Led Review Group.

The SOM has responsibility for overseeing safety processes, to enable assurance to the Patient Safety Incident Response Framework (PSIRF), Executive Review Group, that the true intent of PSIRF is implemented, within the organisation, and the Trust is meeting the National Patient Safety Incident Response Framework Standards

The Executive Led Review Group ensures that the four main aims of PSIRF are implemented and embedded across WHH:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approached to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

There is a daily patient safety triage with the Clinical Governance Team with proactive input from the Care Groups and associated Clinical Business Units. The SOM supports and oversees the operation and decision-making for incident responses.

Trust Executive teams, Clinical Governance Team and appropriate Care Group Triumvirates and associated Clinical Business Unit (CBU) leaders are alerted by email of any incidents of moderate or above grading. The Clinical Governance Team will, support review of all incidents reported to ascertain actual level of harm and identify any immediate actions to ensure patient safety. These incidents are monitored daily and discussed at the daily patient triage meeting to ensure the most appropriate level of investigation is undertaken.

Incidents meeting a lower harm threshold that may be of concern, or where themes are developing, are monitored by the Care Groups and associated CBU's and at the triage meeting and taken forward to SOM for executive oversight when required.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p12-13 below. To fully implement

the Framework the Trust has completed a review of the types of patient safety incidents that occur to understand the learning needs that will inform improvements. The review was again repeated for all incident types reported in 2023-24 to inform decision making. As a result of this further review and discussion with colleagues the decision was that we would continue with the current local priorities

The PSIRF SRO and leadership group has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on p14.

Stakeholder engagement

Planning for PSIRF was commenced on release of National Guidance in August 2022. WHH has worked with a number of the PSIRF early adopters to learn from their approaches, with support from the North-West PSIRF Collaborative network to better understand the practicalities of planning for and implementation of PSIRF.

WHH have had a proactive approach to patient safety incidents embedded for some years now, with consideration given to organisational learning guiding the investigation response. Incidents that did not meet the current SI framework have also been reported as an opportunity for leaning. This approach supports the embedding of the PSIRF culture, and as such sees WHH further developing these attributes as PSIRF transitions and embeds further within the organisation.

Regular contact with Place and the Integrated Care Board (ICB) has seen this approach progress and provides assurance to internal and external stakeholders.

Awareness of PSIRF began early, following initial preparatory work and then the launch of the PSIRF in August 2022, with communications sent Trust wide through the communications teams. This was supported with engagement sessions to Trust board and the wider senior clinical teams. Governance meetings and relevant groups from across the Trust have participated in presentations and discussions to share PSIRF updates and widen knowledge.

It should be noted that whilst priorities have been identified, the Trust remain flexible in utilisation of the toolkit and aim to collaboratively commission the most appropriate investigation based upon the findings of initial investigations. Likewise, incidents of concerns that may not be outlined within stated priorities, must be shown due diligence by investigating appropriately.

Data sources

To define our patient safety response profile, data was drawn from a variety of sources.

Data was collated on the actual incidents that had taken place over the period of the 3 years, that is, from 2020 to 2023. It was decided to look at these years to minimise the possibility of any variation in data arising from the COVID-19 pandemic. Data was collected in financial years – 01/04/2020 to 31/03/2023.

This data was extracted for our initial engagement meetings with key internal stakeholders.

Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident reporting systems
- Complaints, both formal and informal
- Safeguarding reviews
- Freedom to Speak Up
- Mortality Reviews
- Staff survey and learning surveys
- Claims
- Risk
- Data from Quality Surveillance processes
- Coronial information Inquests.

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. We have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

Safety issues highlighted by the data

From the original data review, and the data from 2024/24 we were able to identify the top ten reported incidents by category, level of harm was also considered as part of these reviews. These are shown in the table below. (The term patient is used to describe an individual in receipt of care and treatment, for some services the term service user is preferred):

Category	Descriptor
Medication	All medication issues, including errors, administration, and prescribing.
Infection Prevention and Control	All incidents relating to infection control concerns.
Access, Transfer & Discharge	All incidents related to accessing care, transferring in or out of WHH and discharging concerns.
Patient Fall	All patient falls.
Clinical Care - ongoing &review	All incidents related to a concern in treatment
Skin Damage – Admitted with	All incident where skin damage has been noted upon admission to the Trust.

Assessment, diagnosis, and Investigation	All incidents relating to assessment diagnosis or investigations.
Security	All security incidents
Staffing	All staffing related incidents.
MASD – other wound to skin	All incidents where skin damage has been attributed to a Trust admission.

These were the themes considered, with further details on the subcategories within the themes considered to identify and hone our overall profile. We have also considered items identified which link to current improvement programmes of work and assessed the potential for new learning.

This led to the local focus priorities highlighted on p14 below and which will be our priorities for review under PSIRF.

Whilst the list has been agreed to continue as our priorities, we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

At Warrington and Halton NHS Foundation Trust, we are committed to embedding a culture of continuous improvement to provide the best care possible for our patients. We do this by working together to make slight changes every day as part of our daily work, therefore continually building on the great care that we already provide and striving to make continual improvements for our staff and patients.

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into continuous improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the continuous improvement work we need to undertake.

The Trust established the Quality Academy in June 2018. Its ethos is to apply innovative research and innovation to ensure that clinical excellence is embedded throughout the organisation. This is achieved through continuous quality improvement, collaborating with staff in collaboration with our partners and the public.

The Quality Academy is focusing on building quality improvement capacity and capability at all levels of the organisation by providing different types of improvement training in order to achieve spread and maximise the opportunities for improvement work across the trust.

Our improvement priorities are informed by data analysis and engagement with the Care Groups and CBU's teams around operational and pathway improvement priorities from across the organisation and in line with national requirements. Our improvement work currently comprises a combination of:

- Key improvement priorities arising from national reports, audits, incidents, and complaints (e.g. Infection Prevention and Control, communication with relatives, optimising patient flow)
- Supporting teams taking part in National Collaborative (e.g. MatNeoSIP, MedSIP)
- Trust wide harms reduction priorities supported by the Corporate Nursing Team and the Trust Safety Nurses (e.g. safety huddles, pressure ulcers, falls, VTE)
- Care Group and associated CBU's and service specific improvement projects (e.g. medicines safety, Sepsis)

We have brought together all elements of improvement work currently underway within the Trust. This can be found at **Appendix C**. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated workstream noted.

We plan to focus our efforts going forward on the 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.

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident responses, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

A review of those incidents reported as per Serious Incident Framework (SIF) that required full comprehensive investigations was undertaken for the last three years:

In 2020/21, 40 comprehensive investigations were undertaken and 65 concise investigations.

In 2021/22, 56 comprehensive investigations were undertaken and 78 concise investigations.

In 2022/23, 71 comprehensive investigations were undertaken and 91 concise investigations.

In 2023/24.

- Number of Serious Incident Investigations between April and August 23 – **30**
- Number of Patient Safety Incident Investigations (PSIIs) declared between September 23 and March 24 – **8**
- Number of Concise Investigations – **7**
- Number of After-Action Reviews– **30**
- Number of Multi-Disciplinary Team (MDT) Reviews– **22**
- Number of Swarm Huddles – **1**

	National priority	**Response**
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII by WHH
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII by WHH
3	Maternity and neonatal incidents meeting HSIB criteria	Refer to HSIB for independent PSII
4	Child deaths	Refer for Child Death Overview Panel review. Locally led PSII (or other response) may be required alongside the Panel review
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review

6	Safeguarding incidents in which: Babies, children, and young people are on a child protection plan; looked after plan or a victim of willful neglect or domestic abuse. / Violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Refer to the local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.
7	Incidents in 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
8	Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS	In prison and police custody, any death 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 providers must fully support these investigations where required to do so.
9	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)	Locally led PSII by the provider in which the event occurred with WHH participation as required
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII. Locally led PSII may be required with mental health provider as lead and WHH participation if required

11	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 the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through analysis of patient safety insights, based on the review of incidents and engagement meetings and workshops the Trust have determined 3 patient safety priorities as local focus. This will enable us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII's to inform our patient safety improvement planning through continuous improvement.

	Incident type	Description	Response type
1	Assessment, Diagnosis, and Investigation	Potential for harm when there is a missed or delayed diagnosis of a cancer.	PSII
2	Clinical Care - ongoing &review	Potential for harm when there is a delay in the identification, recognition and response to patient deterioration resulting in delayed escalation and treatment.	PSII
3	Assessment, diagnosis, and Investigation	Potential for harm when there is a delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)	PSII

For any incident not meeting the PSII criteria, or any other incident, we will use specific patient safety review tools to enable a learning response. For lesser harm/incidents we propose to manage these at a local level along with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work and audit.

The specific patient safety review tools that the organisation have agreed to adopt are as follows:

- Initial Safety Reviews (ISR)

- After Action Reviews
- Multi-Disciplinary Reviews
- Swarm
- Case Note Reviews/Clinical Reviews

Appendix A

Glossary of terms

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan
Our local plan sets out how we will conduct the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

ISR – Initial safety Reviews
This is a rapid review usually completed with subject matter expert (decision maker) and designated Governance manager (or designated other) within 3 working days (72 hours to determine if further review or investigation is required. The findings are uploaded directly onto the Datix system in bullet point form and associated actions identified.

AAR – After action review
A method of local evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review
Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

SMART

SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved, or targets might slip

Appendix B

Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS FT

Organogram

WHH Organisational Chart - MASTER .pptx

Appendix C

Improvement programmes

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Building improvement capability				
1	Increase uptake of existing QI training programmes through: - improved communications - engagement with care groups and CBU leadership - exploring CPD accreditation	Participation in QI Foundation and QI Practitioner training *Aim: 10% of staff (400) trained to QI Foundation level and 2.5% of staff (100) completed QI Practitioner.*	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	Ongoing Q1-Q4
2	Implement the QI training delivery plan including: - Develop a leadership for improvement training offer, aligned to emerging NHS England programme (Q2-Q3) - Develop and implement a QI coaching programme (Q2-Q4) - Develop a series of bitesize modules (Q2) - Explore options for development of e-learning package (Q4)	Course content developed Participants enrolled Options appraisal for e-learning	Support from Comms team to deliver Comms and engagement plan Care group and CBU leadership Support and governance arrangements for monitoring in place Support from partners e.g. AQuA, Q community Coaching SIG, subject matter experts QI team capacity and capability to deliver Suitable venues Budget for	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work People - Growing our WHH Workforce for the future	Q2-Q4
3	Internal QI team development to meet the evolving needs of the service and Trust	PDR with training and development plan in place for all team members, aligned to service need alongside personal priorities Staff Retention	Access to CPD funding where required Access to external training courses	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Growing our WHH Workforce for the future	01/06/2023 Ongoing

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Build and sustain a culture of continuous improvement				
4	Support CQC Preparedness: Moving to Outstanding by: - QI involvement in the CQC mock inspection prgoramme - support to use QI methods and tools where requirements for improvement identified - support the use of SPC charts and regular measurement to monitor QI outcomes and ensure sustained improvement	Completion of self-assessment of QI, learning and innovation section of CQC well-led framework *Aim: Achieve 80% Quality Improvement assessment score in line with CQC maturity matrix.* Attendance at relevant CQC meetings and involvement in mock inspections QIPs identified through or	QI team capacity	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q1-Q4
5	Implementation of QI communication and engagement plan	Improved uptake of training courses Increase in QIP registrations Improved quality and outcomes of completed	Support from comms team	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
6	Improve oversight and governance arrangements for QI work at Care group and CBU level	Clear escalation routes for QIPs Reduction in number of discontinued QIPs Improved quality of QIPs Improved oversight and uptake of training Improved alignment of workplans with other teams e.g. transformation	Care group and CBU leadership Support	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Q2
7	Continue to showcase Quality Academy and improvement work and celebrate successes across the organisation, including: (e.g. World Quality Week) - promoting and supporting annual events e.g. Quality Academy Showcase, world Quality Week - Celebration events for QI practitioner participants	Attendance and engagement with celebration events Spread of improvements beyond original location/service	Senior leadership support and attendance at events Support from communications team Budget for refreshments, etc	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Ongoing Q1-Q4
8	Support the develoment of a systematic approach to shared learning, e.g. through the development of a trustwide learning forum	Attendance at learning forum Evaluation of learning forum events	Senior leadership support and attendance at events Support from communications team Budget for refreshments, etc	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework Quality Priority 6 - Improve and embed a culture of Quality Improvement	Q3

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	Action to be taken	How will you measure/monitor whether this has been achieved?	What resource is required?	How does this link to Trust strategy?	Deadline for delivery
	Support application of QI methods to Trust and service strategic improvement areas				
9	Support the delivery of 2023-24 Quality Priorities through coaching, advice and guidance to support use of QI methodologies	Attendance and involvement in relevant working groups Application of QI methods to delivery	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
10	Support the delivery of the 23-24 CQUINS through coaching, advice and guidance to support use of QI methodologies	Application of QI methods to CQUIN delivery QIPs identified through or linked to CQUINS	Support and leadership from identified project leads	Quality: Patient Safety Quality: Clinical Effectiveness Quality: Patient Experience	Ongoing Q1-Q4
11	Support the implementation of PSIRF	Active involvement in the PSIRF implementation group QIPs identified through or linked to local priorities identified within PSIRP	Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	Ongoing Q1-Q4
12	Support Trust participation in national patient safety collaboratives, e.g. Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), Medicines Safety Improvement Programme (MedSIP)		Support and leadership from identified project leads	Quality Priority 3 Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework	
13	Support Care Groups and CBUs to apply QI methods to deliver annual priorities and ad hoc	Application of QI methods QIPs registered within each CBU	Care group and CBU leadership Support and governance arrangements for monitoring in place QI team capacity	Quality People Sustainability	Ongoing Q1-Q4

	Specific	Measurable	Attainable	Relevant	Time-bound
Action ref	**Action to be taken**	**How will you measure/monitor whether this has been achieved?**	**What resource is required?**	**How does this link to Trust strategy?**	**Deadline for delivery**
	Further develop QI systems and processes				
14	Review and further develop the QIP registration process, including: - QIP registration form - Clear criteria for registering as a QIP - Development of a standardised approach and crtieria to assess QIP quality and outcomes	Revised process following workshop with relevant staff Digitised registration form Updated project type flow chart (to include transformation, patient experience, etc)	Support and engagement from other team leads to clarify distinctions between project types	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q2
15	Further develop the QI toolkit, resources and project documentation	Updated toolkit/resource pack ? Number ofownloads	Support from Comms team to format and ? access download data	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation	Q3
16	Establish and raise awareness of defined QI project roles and responsibilities e.g. SRO, project lead, team member	Clearly defined and documented roles and responsiblities Engagement of key project roles in QI projects	Support from senior leaders, project leads and team members	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation People - Innovating the way we work	Q1
17	Increase involvement of patient and service users in QI projects	Number of projects involving service user representation	Support from engagement and involvement officer and experts by experience	Quality Priority 6 - Improve and embed a culture of Quality Improvement across the organisation Quality: Patient Experience People - Innovating the way we work	Ongoing Q1-Q4

Supporting application of QI methods to strategic improvement areas