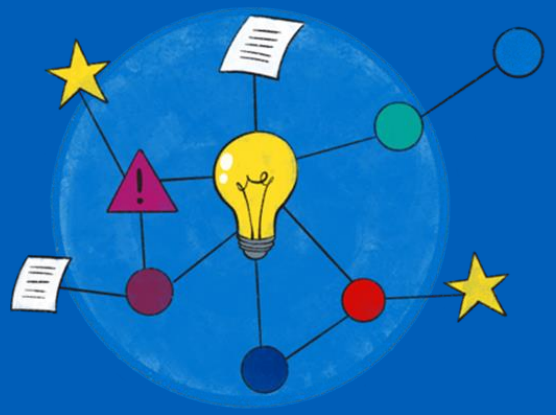
National Patient Safety Improvement Programmes

NHS

System Safety

Welcome to:



Safety, systems and support – planning for PSIRF together

Tuesday 28th February 2023, 0930 - 1600

North East & North Cumbria Patient Safety Collaborative

Academic Health Science Network North East and North Cumbria

Yorkshire & Humber Patient Safety Collaborative

YORKSHIRE & HUMBER ACADEMIC HEALTH SCIENCE NETWORK

Improvement Academy

NHS England North East & Yorkshire

NHS England North East and Yorkshire

North East Commissioning Support

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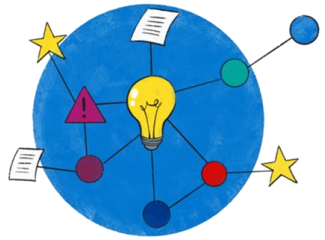
Welcome and introduction



Wendy Halliburton

Patient Safety Lead & Work Stream Lead for System Safety

AHSN North East & North Cumbria

wendy.halliburton@ahsn_nenc.org.uk

@PSSpecialistNE @AHSN_NENC

Melanie Johnson

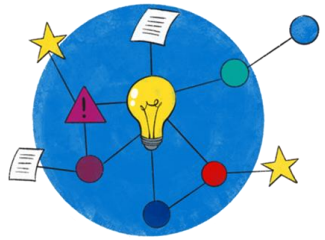
Patient Safety Collaborative Programme Manager

Yorkshire & Humber AHSN

Melanie.Johnson@yhia.nhs.uk

@Improve_Academy @YHAHSN

Housekeeping & ground rules



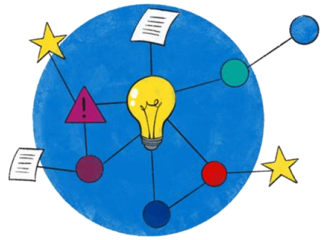
- Photos & social media consent
- Social media

  #psirfnenc #psirfyh #psirftogether
- Phones on silent / please take calls in the lobby
- Fire alarms
- Toilets
- Breaks

Ground rules for productivity

- Clear objectives for each session
- Everyone is equal
- Listen respectfully
- Participate honestly and candidly
- Maintain confidentiality
- Keep an open mind; suspend personal agendas
- Stay focused on our objective / purpose

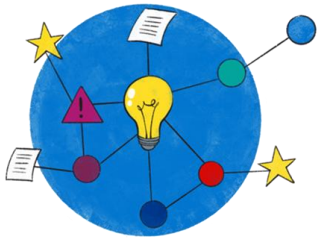
Purpose of the event



To bring together PSIRF implementation teams from providers and the ICBs to share their learning from the early phases of implementing PSIRF and to work collaboratively on the upcoming phases of implementation, ensuring a regional approach to **learning from patient safety events**.

To embrace the spirit of PSIRF to ensure successful implementation.

Today's Objectives



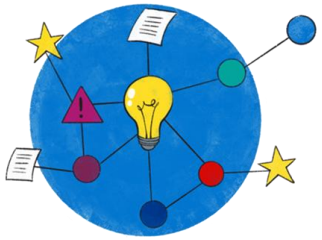
- To provide the opportunity for networking and sharing good practice across providers / ICSs
- To support the implementation of the Patient Safety Incident Response Framework (PSIRF) across the North East and Yorkshire regions
- To share knowledge, insight and experiences to help support our teams
- Provide a space for each ICS / provider to focus on where they are now in the implementation of PSIRF and what their next actions need to be (focusing on governance & oversight)
- Share what support is currently available from National and Regional teams and discuss and identify what support ICS's / providers need for upcoming phases

Agenda

*Q&A: Slido.com #5125867

Time	Session	Facilitator
09:30	Welcome and housekeeping	Wendy Halliburton, AHSN NENC & Mel Johnson, YHIA
09:40	Welcome & the role of NHSE regional team	Karen Conway, NHSE Regional team
09:55	Safer Systems – the national perspective (Q&A)*	Tracey Herlihey & Lauren Mosely, NHSE Patient Safety
10:40	Learning from the pilots – How to develop a systems approach to support PSIRF	Angela Edmunds, Leeds Health and Care Partnership Richard Gibson, Leeds Teaching Hospitals
11:10	**Comfort Break (15 minutes)**	
11:25	Patient Safety Partners – role, purpose & added value in governance and oversight	Kate Jones, South Tees NHS Foundation Trust
11:45	PSIRF implementation – how can we measure the impact?	Dr Gemma Louch, University of Leeds
12:05	So far, so good?	Mel Johnson, YHIA & Wendy Halliburton, AHSN NENC
12:20	**Lunch (45 minutes)**	
13:05	Afternoon workshops	Mel Johnson, YHIA & Wendy Halliburton, AHSN NENC

Welcome & the role of NHSE regional team



Karen Conway

Deputy Director Clinical Quality & Patient Safety Specialist

NHS England North East and Yorkshire

Patient Safety Incident Response Framework

Karen Conway
Deputy Director of Clinical Quality
NHS England North East and Yorkshire Region
February 2023

Regional Team

- Regional response/actions in relation to serious lapses in patient safety
- Coordination of cross system responses to patient safety incidents
- Oversight focus - enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality
- Identify incidents that may require an independent PSII
- Mental Healthcare related homicides /other types of Independent Investigations
- Ensure high quality Independent Investigations are commissioned

Regional Team

- Escalate systemic or systematic risks across services that require a national response
- Advising, guiding access to the Independent PSII Supplier Framework (available to all NHS-commissioned services and ICBs)
- Involved in investigation commissioning decisions for those incident investigations requiring the involvement of and liaison between multiple external agencies (Police, LAs and/or ICBs)
- Collaboration with AHSNs to support ICB/Provider PSIRF Leads
- Support a learning system

PSIRF Preparation Guide (Aug 2022)
Plan on a page

Month →	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Phase ↓	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1	PSIRF orientation																				
2					Diagnostic and discovery																
3							Governance and quality monitoring														
4								Patient safety incident response planning													
5										Curation and agreement of the patient safety incident response policy and plan											
6													Transition – working under the patient safety incident response policy and plan								
7																Embedding sustainable change and improvement					

Phase	1. Orientation		Diagnostic & discovery		Governance & quality		PSIRP		Draft policy & plan		Transition		Embedding	
Month	Months 1-3		Months 4-7		Months 6-9		Months 7-10		Months 9-12		Months 12-16		Months 15 onwards	
Actions	1.1	Create an implementation team	2.1	What is being done to support open and transparent reporting?	3.1	Develop processes for incident response decision making	4.1	Map your services	5.1	Populate the policy and plan templates and sahre these with stakeholders	Here be dragons.....			
	1.2	Allocate time for reading and reflection	2.2	How do you engage and involve those affected by patient safety incidents?	3.2	Define how system effectiveness will be monitored	4.2	Examine patient safety incident records and safety data	5.2	Respond to stakeholder feedback on the draft policy and plan				
	1.3	Identify knowledge and support needs for getting started	2.3	What is being done to support the development of a just culture?	3.3	Develop processes for reporting cross-system issues	4.3	Describe the safety issues revealed by the data	5.3	Agree how to manage transition				
	1.4	Create a stakeholder list and plan engagement	2.4	What is your incident response capacity and what are your training needs?	3.4	Define how system effectiveness will be monitored	4.4	Identify work underway to address contributory factors	5.4	Ensure commitment to delivering required improvement				
	1.5	Agree structures and process for programme management	2.5	How do you use learning from incident responses to inform improvement?			4.5	Agree how you intend to respond to issues listed in your patient safety incident profile	5.5	Seek policy and plan approval / sign off and agree 'transition date'				
	1.6	Set ambition for PSIRF implementation	2.6	What do you need to do next?										

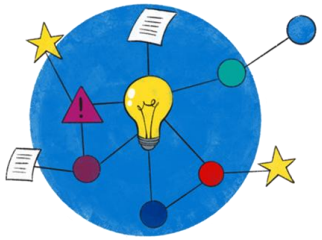
Governance and oversight

- Systems/mechanisms for oversight should be designed to allow organisations to demonstrate improvement rather than compliance (prescriptive, centrally mandated measures)
- Oversight under PSIRF (although needs to be locally adapted) focuses on engagement and empowerment rather than the more traditional command and control
- Reduce the information requests/collection burden (new NEY regional oversight and PSIRF steering groups with ICBs/AHSNs being established

PSIRF Support offer

- Continue with NHSE/AHSN Patient Safety Specialist Networks (inevitable focus currently is PSIRF)
- PSIRF Oversight training and education pending for ICB/NHSE Leads
- Non Executive Director awareness and education pending
- Providers – how can we help?

Safer Systems – the national perspective
Q&A and feedback following the national webinars



Tracey Herlihey

Head of Patient Safety Incident Response Policy

NHS England

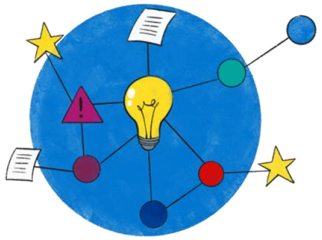
Lauren Mosely

Head of Patient Safety Implementation

NHS England

Q&A:
Slido.com
#5125867

Developing a systems approach to support PSIRF



Angela Edmunds

Head of Quality Improvement and Patient Safety

Leeds Health and Care Partnership

Richard Gibson

Serious Incident Investigations & Learning Manager

Leeds Teaching Hospitals NHS Trust

Leeds Health & Care Partnership

Patient Safety Incident Response Framework (PSIRF)

- The Leeds experience of developing a systems approach to support PSIRF

Angela Edmunds
Head of Quality Improvement and Patient Safety
The WY ICB in Leeds

Richard Gibson
Serious Incident Investigations & Learning Manager
Leeds Teaching Hospitals NHS Trust (LTHT)

#TeamLeeds

Firstly a bit about us…..

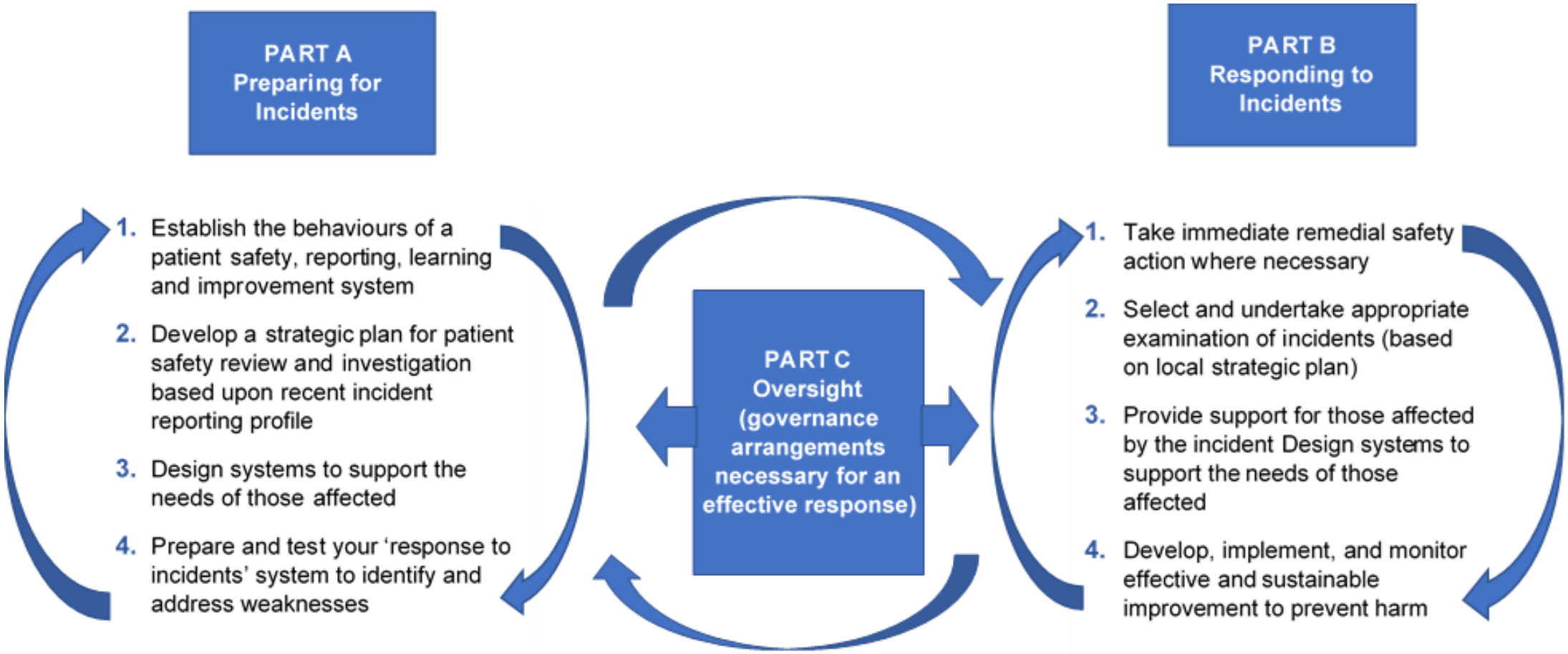
NHS West Yorkshire Integrated Care Board

City of Leeds district has a population of 812,000 (2021 estimate);

The Leeds health and Care partnership consists of;

- 3 large providers for acute, community and mental health services (LTHT, LCH and LYPFT)
- Local City Council (LCC)
- 3 Hospices (St Gemma's, Wheatfields and Martin House)
- 92 GP practices
- 147 care homes and over 100 domiciliary care providers
- 5 host commissioner sites (under the LD and autism host commissioner framework)
- Number of other independent and smaller providers who deliver NHS services

Overview of PSIRF



Copied from NHS Patient Safety Incident Response Framework FINAL.pdf, p.8

Implementation guide: plan on a page

Leeds Health & Care Partnership

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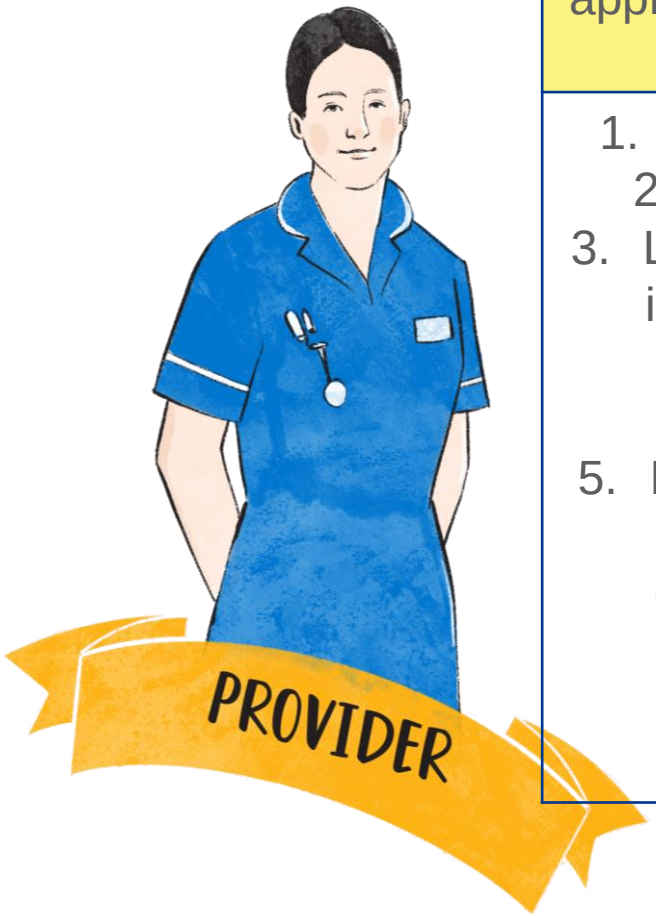
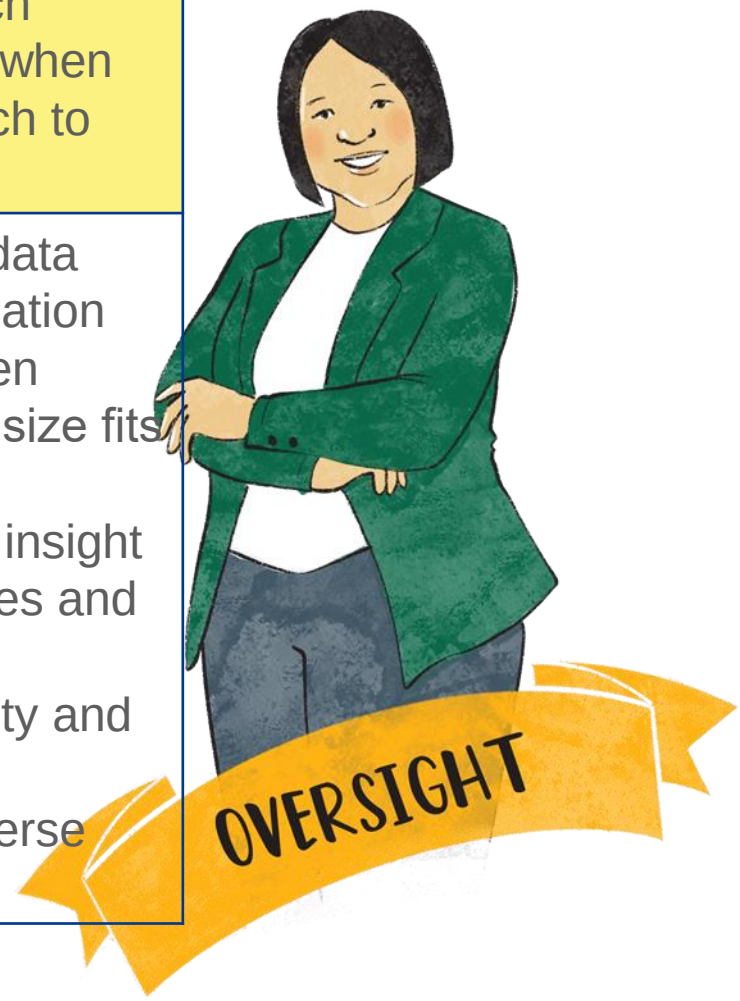
Supportive system oversight

Leeds Health & Care Partnership



Oversight mindset Should underpin oversight approach from provider boards, ICBs and CQC	Oversight approach Principles to consider when designing an approach to oversight
1. Improvement is the focus 2. Blame restricts insight 3. Learning from patient safety incidents is a proactive step towards improvement 4. Collaboration is key 5. Psychological safety allows learning to occur 6. Curiosity is powerful	1. Use a variety of data 2. Reduce the information collection burden 3. Oversight is not 'one size fits all' 4. Capture meaningful insight from patients, families and staff 5. Metrics require clarity and purpose 6. Be aware of perverse incentives



Requirements for Providers

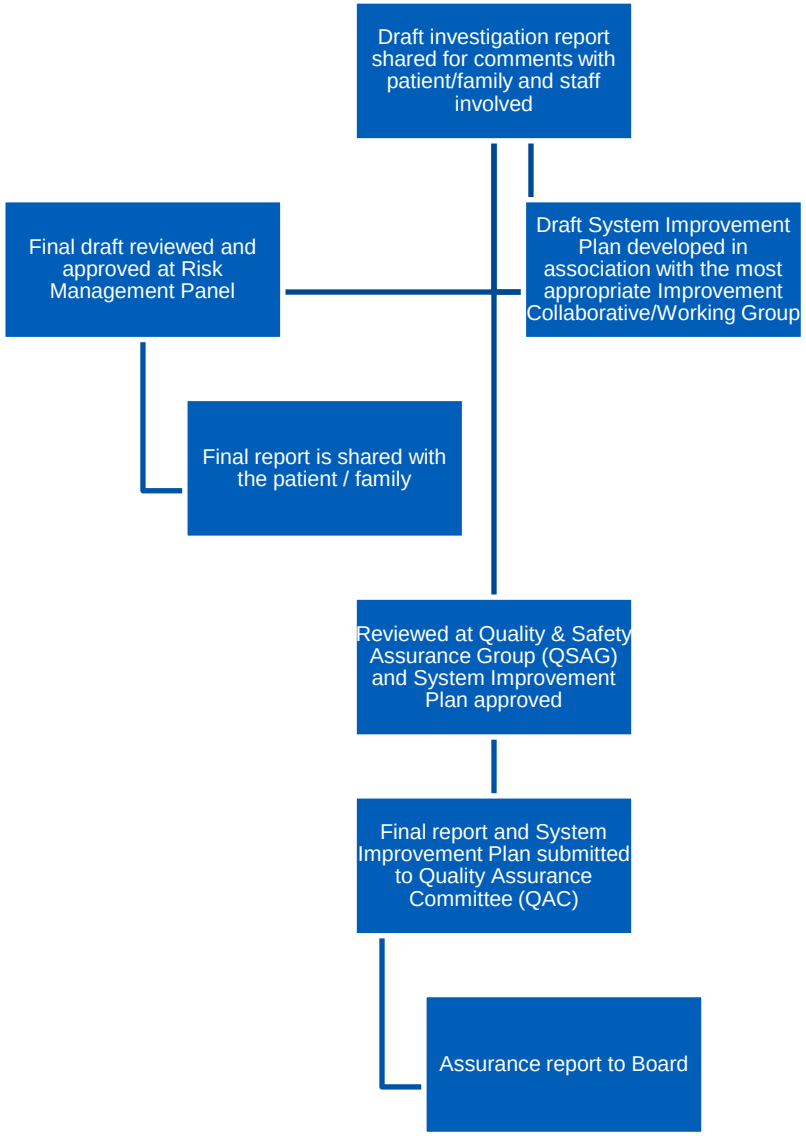
Leeds Health & Care Partnership

Phase	Requirements for providers
PSIRF orientation/ getting started	• Becoming familiar with new documentation, principles and expectation • Creating a PSIRF implementation team/lead • Consideration of structure/how PSIR systems and plans will be organised • Engagement and communication with stakeholders • Setting ambition and creating local implementation plans
Diagnostic/ discovery	• Understanding how developed systems and processes are, identify strengths and weaknesses, improve and/or maintain efforts in areas which will support PSIRF Implementation (e.g. openness/ transparency/ just culture/ etc). • Output should be i) comprehensive understanding about current systems and processes to support the way patient safety incidents are responded to and ii) an agreed approach to improve or maintain the development of a system as required in line with **patient safety incident response standards**
Identifying measures of success and quality monitoring	• Create a process to monitor preparation progress • Create a processes to measure the success of PSIRF
Patient Safety Incident Response planning	• Identifying patient safety issues within services • Agree how these issues will be responded to (e.g., learning, improvement, review)
Curation of Patient Safety Incident Response Policy and Plan	• Develop and agree new documentation to guide local processes • Agree transition date (i.e. when new policies will take effect) • Ensure shared understanding about: o a cut-off date for accepting incidents for investigation under the SIF o a date for completing investigations under the SIF or agreement on an overlap phase o ensuring that all relevant staff know the transition date/phase and what they are required to do/how this affects them

LTHT journey

- Pilot site in 2019; stalled in 2020 due to the covid pandemic
- Worked jointly with CCG/ICB from the beginning of the Early Adopter Programme
- CCG/ICB attendance at LTHT monthly PSIRF Programme Board meeting
- LTHT PSIRP signed off by CCG
- PSIRP implemented April 2022
- Quarterly update against PSIRP fed in to ICB (on progress against plan)
- Agenda item on monthly Leeds Place Patient Safety Specialists network meeting

LTHT Internal Oversight Structure



Challenges

- Capacity
- Accessing training, relevant for organisational needs
- Changing culture within the organisation and across the local system
- Understanding roles/responsibilities (e.g. across service units and incident management team)
- And…..

ICB roles and relationships

Key requirements are to:

- Collaborate in the development of PSIR policy and PSIRP
- Develop new processes to support oversight of effectiveness of systems in place to respond to patient safety incidents
- Ensure training/competency standards are met for those in oversight roles
- Support cross system response
- Establish supportive learning system across the ICS itself, reflecting the sprit of partnership and collaboration

Challenges

- Transition from Serious Incident Framework (SIF) & double running of systems
- Supporting providers at different stages of their PSIRF
- Resisting tendency to 'count widgets'
- Establishing governance processes at place and wider ICB
- Developing the role of ICB and alignment with other stakeholders
- Supporting interdependencies with STEIS, NRLS, LFPSE and provider Local risk management systems (LRMS) i.e. datix or equivalent
- Agreeing priorities in the local system across all providers

Working together

- Established city wide Patient Safety Specialist Network
- Engaging with all providers in the ICB in Leeds geography and offering support
- Linked quality Managers from the ICB in Leeds Quality team with providers to support local development and implementation plans
- Remembering 'one size does not fit all'
- Update reports provided to the Leeds Health Care Partnership Quality and People's Experience Committee (QPEC)
- Terms of reference created for multi agency review of patient safety events
- Provider Quality Engagement Meetings (replaced CQRGs)

Next steps

Embedding learning and continuous improvement

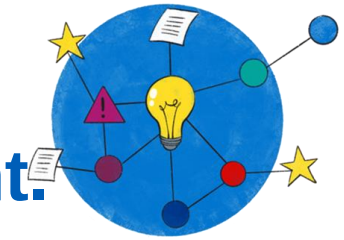
- Planning for a local system wide PSIRF learning event in May 2023
- To develop a lessons learnt group in Leeds to bring all reported intelligence around patient safety together and support place level improvement action
- Continue to develop governance framework for sign off multiple provider policies/plans
- Continue to support provider development of implementation plans and their PSIRPS
- New narrative to be added to contract particulars to reflect expectations and reporting requirements around PSIRF

Angela Edmunds
Richard Gibson

Leeds
Health & Care
Partnership


break
time

Patient Safety Partners -
Role, purpose & added value in governance and oversight.



Kate Jones

Associate Director of Patient Safety

South Tees NHS Foundation Trust

Our Patient Safety Partners

- Proposal regarding PSP role presented at Safe & Effective Care Strategic Group in June 2022
- Advertised the role in August 2022; deliberately avoided doing this via NHS jobs and used the Trust's social media platforms with a link to the role profile instead, inviting written expressions of interest. The advert was also shared with patient networks (Healthwatch, Hart Gables, BME, Age UK, Carers Plus etc)
- Informal interviews held in October with AMD and ADPS

Our Patient Safety Partners

- Undertaken DBS checks
- ID badges, nhs.net accounts, renumeration and induction
- PSPs began to attend our Patient Safety Committee in Dec 22

Our Patient Safety Partners

- Mike – served as governor for the Trust for 6 years
- Previously worked in customer facing roles for 30 years and has an in-depth knowledge of the importance of understanding and addressing service user needs to deliver optimal outcomes
- Family members have received care and treatment from the Trust

Our Patient Safety Partners

- Norman – vast experience of training design and delivery in the RAF
- Consultant delivering HF to airlines
- HF manager for Cathay Pacific
- Authored book relating to systems view of airline pilot behaviour

Our Patient Safety Partners

- Clare – teacher for children with emotional, behavioral and/or social difficulties
- Partner received care and treatment from the Trust
- Clare's partner died following a patient safety incident at the Trust, which was reported as a Serious Incident, referred to HM Coroner and investigated by Cleveland Police

Roles for Patient Safety Partners

Currently:

- Existing members of Trust's Patient Safety Steering Group
- PSPs attend PSIRF planning meetings
- One of the PSPs has attended our PSIRF investigation training provided by Consequence UK

Roles for Patient Safety Partners

In the next 6 months:

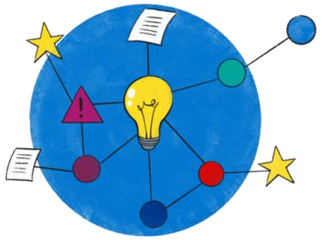
- Advising regarding content of communication with patients (e.g. LTFU)
- Advising regarding patient safety training
- Advising regarding Trust's strategy for engaging with harmed patients and their families
- Co-design of PSIRF documentation that will be shared with patients and families

Roles for Patient Safety Partners

In the next 6 months (continued):

- Speaking at the Trust's Patient Safety Day about personal experience of patient safety processes
- Co-designing the Trust's approach to PSP involvement
- Participation in observational audits of safety critical processes
- Reviewing patient safety learning responses

PSIRF implementation – How can we measure the impact?

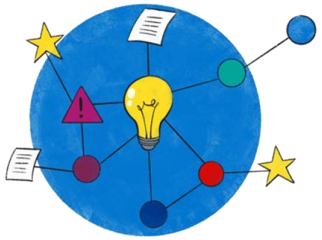


Gemma Louch

Research Programme Manager for the Response Study

School of Healthcare; University of Leeds

So far, so good?



Wendy Halliburton

Patient Safety Lead & Work Stream Lead for System Safety

North East & North Cumbria

Melanie Johnson

Patient Safety Collaborative Programme Manager

Yorkshire & Humber AHSN

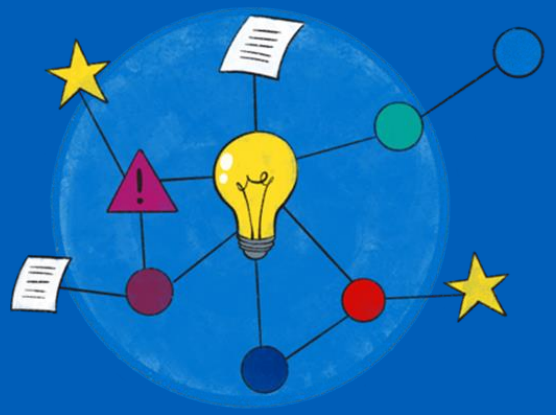

LUNCH
BREAK

National Patient Safety Improvement Programmes

NHS

System Safety

Welcome to:



Safety, systems and support – planning for PSIRF together

Tuesday 28th February 2023, 0930 - 1600

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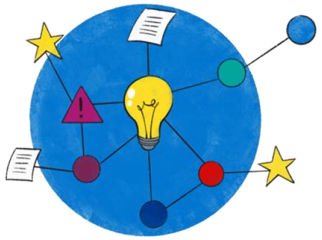
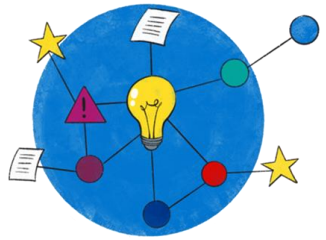
Afternoon with NENC

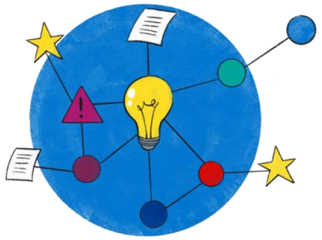


Time	Session	Facilitator
13:05	Welcome back….	Wendy Halliburton
13:10	Welcome & the role of the ICB	Maureen Grieveson, NENC ICB
13:15	Training needs café	Wendy Halliburton & Julia Wood
14:30	**Coffee break (15 minutes)**	
14:45	Oversight workshop	Wendy Halliburton & Julia Wood
15:30	How did we do? & What next?	Wendy Halliburton
15:55	Close & thank you	Wendy Halliburton

Please provide your feedback on the event via the QR code:



Welcome & the role of the ICB

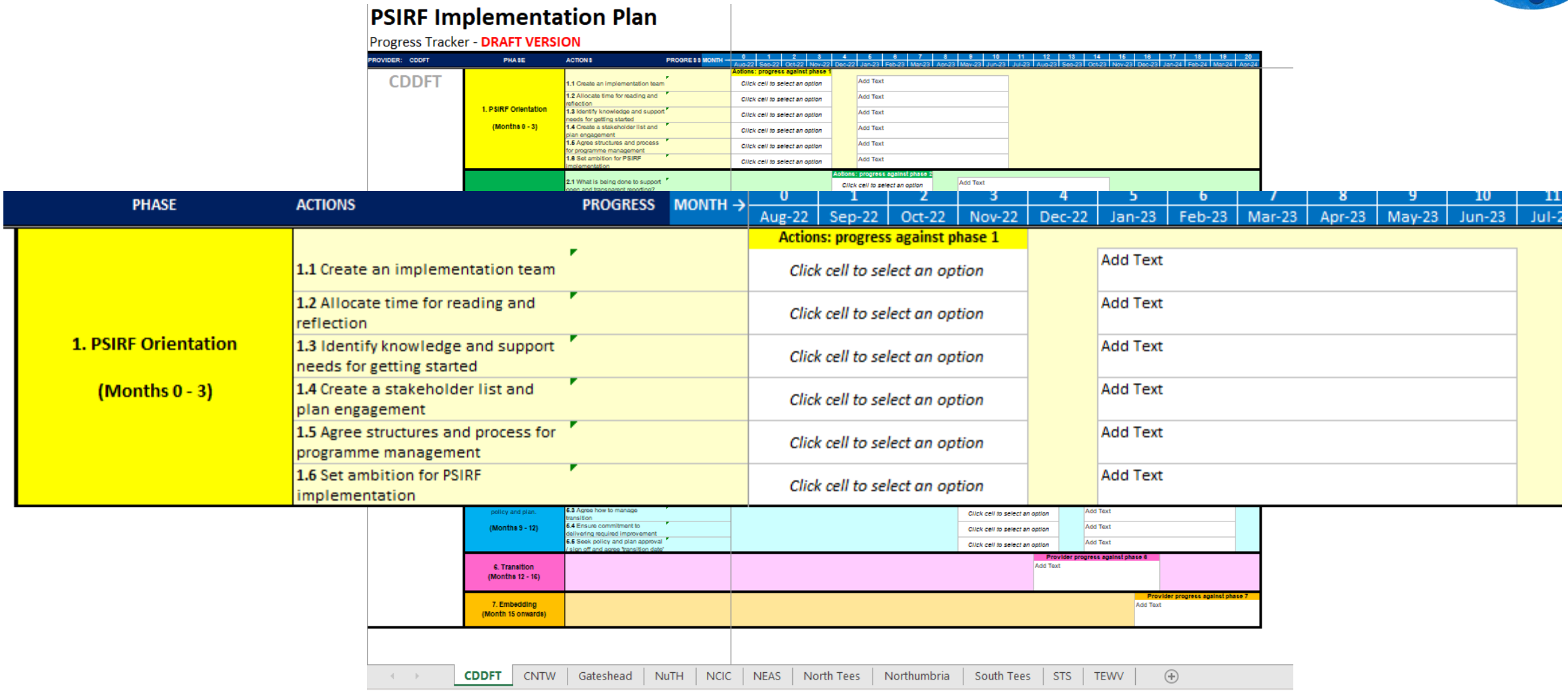


Maureen Grieveson

Director of Nursing Corporate & PSIRF implementation lead

NENC ICB

Provider implementation tracker



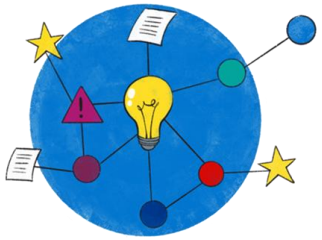
PSIRF Implementation Plan

Progress Tracker - **DRAFT VERSION**

PHASE	ACTIONS	PROGRESS	MONTH → 0 Aug-22	1 Sep-22	2 Oct-22	3 Nov-22	4 Dec-22	5 Jan-23	6 Feb-23	7 Mar-23	8 Apr-23	9 May-23	10 Jun-23	11 Jul-23
			Actions: progress against phase 1											
1. PSIRF Orientation (Months 0 - 3)	1.1 Create an implementation team		Click cell to select an option											Add Text
	1.2 Allocate time for reading and reflection		Click cell to select an option											Add Text
	1.3 Identify knowledge and support needs for getting started		Click cell to select an option											Add Text
	1.4 Create a stakeholder list and plan engagement		Click cell to select an option											Add Text
	1.5 Agree structures and process for programme management		Click cell to select an option											Add Text
	1.6 Set ambition for PSIRF implementation		Click cell to select an option											Add Text

CDDFT | CNTW | Gateshead | NuTH | NCIC | NEAS | North Tees | Northumbria | South Tees | STS | TEWV

Workshops

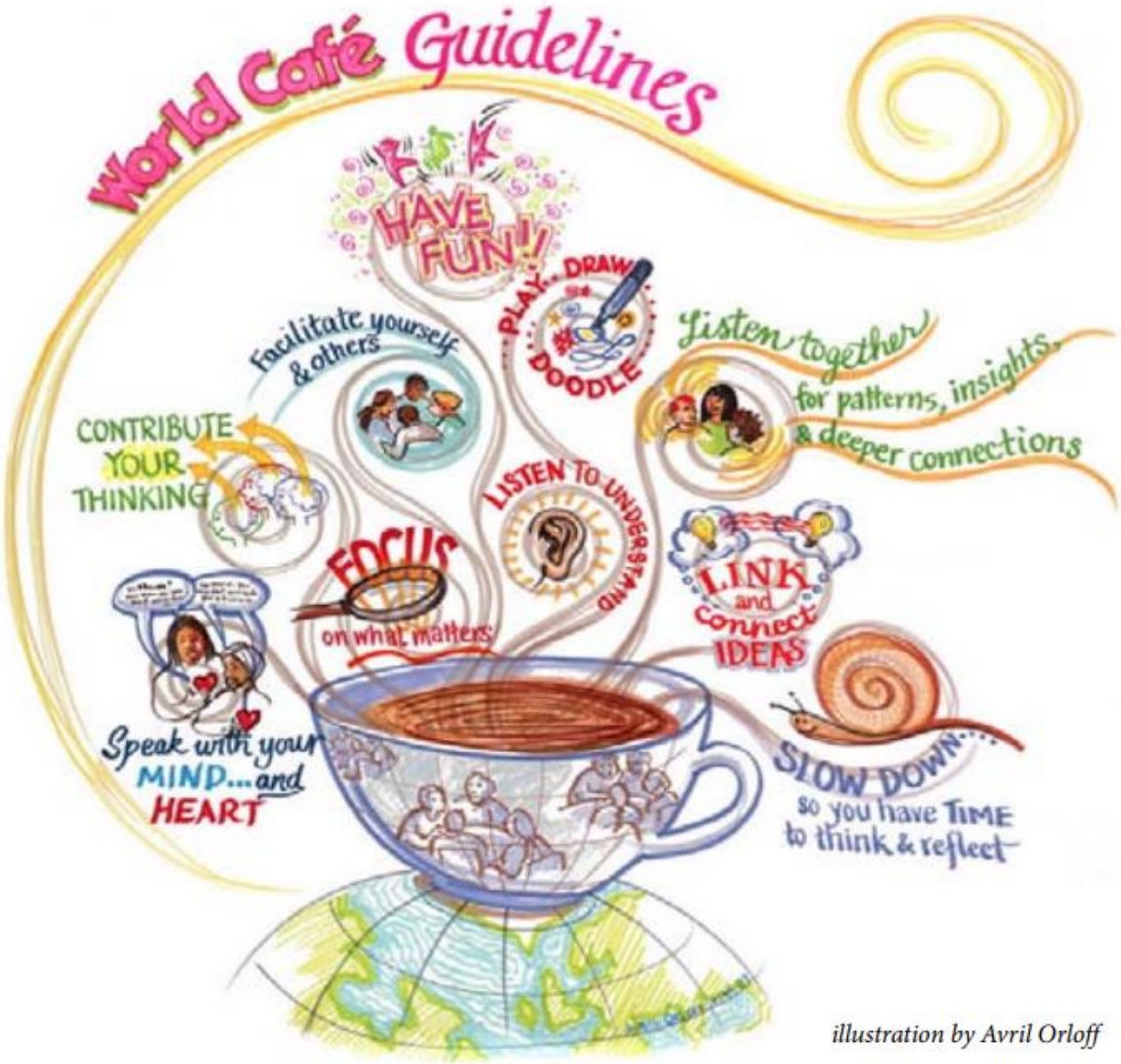


- Training needs café — 1 hour 15 minutes
  - World café format
    - Get to know each other and network
    - Cover a large topic in short sections
    - Bring together everyone's ideas

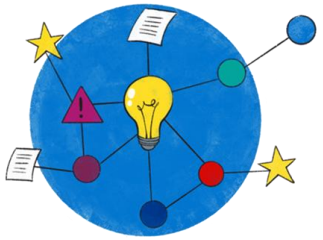
- Oversight workshop — 45 minutes
  - Liberating structures – what do I need from you?
    - Understand everybody’s roles & responsibilities
    - Explore how to work as a ‘system’ to gain the most learning

Training needs café

- 3 x 20 minute rounds
- One ‘host’ / facilitator to remain at each table
- Discuss ONE topic for 20 minutes, then move to another table
- Brief introductions and ‘dance cards’
- Doodle your thoughts & ideas on the paper
- Harvest! Gather insights from the discussions



Training needs café questions



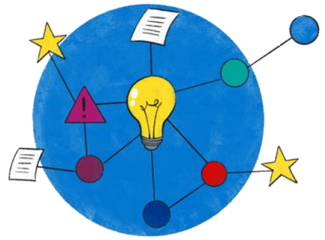
1. Who requires training in your organisation?
   - Does one size fit all? Who? Role? Band? Previous training?

2. What are the barriers to accessing training?
   - Virtual / in person? Cost? Releasing staff? Appropriate level? Value added?

3. How can we overcome the barriers?
   - Think system / region. What resources can we draw on?


break
time

Oversight workshop



Three **elements** that require oversight:

- Policies & plans
- Learning responses (PSII & reviews)
- Safety actions & improvements

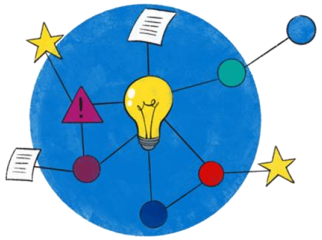
Three **levels** of oversight within the system:

- Provider
- ICB / commissioner
- NHSE / Regulator

The system for oversight should be designed “in a way that allows organisations to demonstrate improvement, rather than compliance with prescriptive, centrally mandated measures”

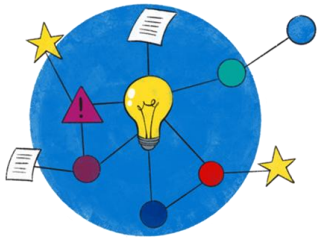
Oversight under PSIRF focuses on engagement and empowerment rather than traditional command and control.

Oversight workshop questions



- What do I need from you?
  - What do you want to know? How much are you / am I willing to share?
- Who ‘owns’ it?
  - Who develops it? Who agrees it / signs it off? Who monitors its progress?
- How do we ensure quality? How do we measure success?
  - What is quality? Who determines quality? What does success look like?
- How do we work as a system to ensure improvement?
  - How do we move away from ‘tick box’ compliance to learning & improvement?

How did we do?



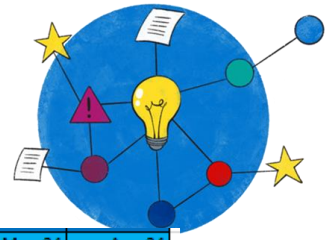
Wendy Halliburton

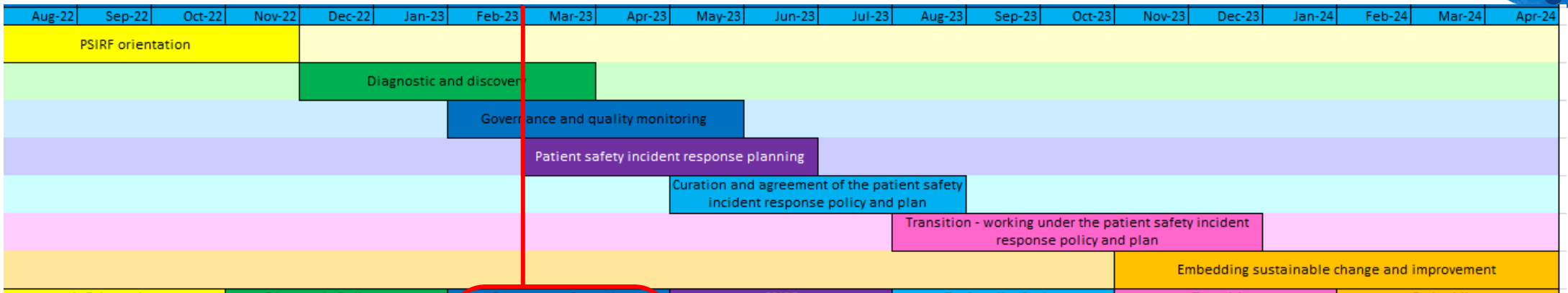
Patient Safety Lead

North East & North Cumbria

Please provide your feedback on the event via the QR code

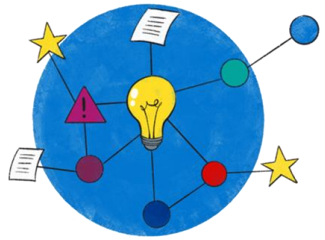
Where are we now?





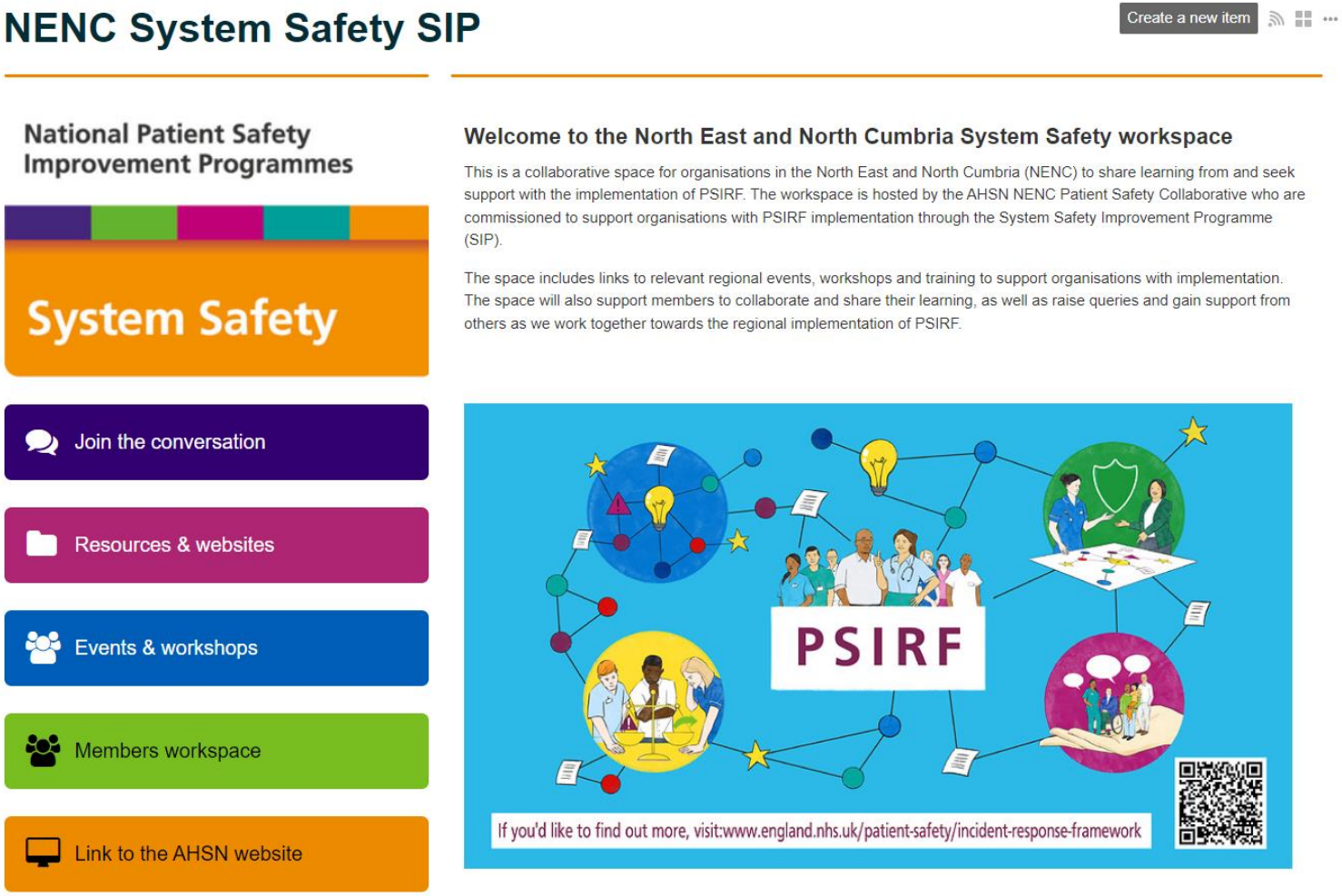
1. Orientation		Diagnostic & discovery		Governance & quality		PSIRP		Draft policy & plan		Transition		Embedding	
Months 1-3		Months 4-7		Months 6-9		Months 7-10		Months 9-12		Months 12-16		Months 15 onwards	
1.1	Create an implementation team	2.1	What is being done to support open and transparent reporting?	3.1	Develop processes for incident response decision making	4.1	Map your services	5.1	Populate the policy and plan templates and sahre these with stakeholders	Here be dragons.....			
1.2	Allocate time for reading and reflection	2.2	How do you engage and involve those affected by patient safety incidents?	3.2	Define how system effectiveness will be monitored	4.2	Examine patient safety incident records and safety data	5.2	Respond to stakeholder feedback on the draft policy and plan				
1.3	Identify knowledge and support needs for getting started	2.3	What is being done to support the development of a just culture?	3.3	Develop processes for reporting cross-system issues	4.3	Describe the safety issues revealed by the data	5.3	Agree how to manage transition				
1.4	Create a stakeholder list and plan engagement	2.4	What is your incident response capacity and what are your training needs?	3.4	Define how PSIRF implementation will be monitored	4.4	Identify work underway to address contributory factors	5.4	Ensure commitment to delivering required improvement				
1.5	Agree structures and process for programme management	2.5	How do you use learning from incident responses to inform improvement?			4.5	Agree how you intend to respond to issues listed in your patient safety incident profile	5.5	Seek policy and plan approval / sign off and agree 'transition date'				
1.6	Set ambition for PSIRF implementation	2.6	What do you need to do next?										

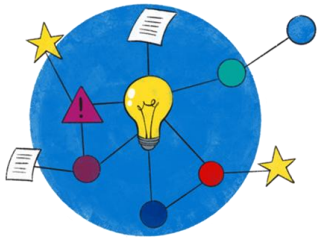
National and Regional support



Offer	Details	Date/Time
NHSE national webinars	PSIRF Transition Support webinars to guide you through each phase: Governance → Planning Planning → Curation Curation → Transition Transition → Embedding	All webinars 14:00-15:00 13 March 9 May 10 July 11 Sept
Regional Patient Safety Group (CDDFT) → Patient Safety Improvement Network (ICS)	Patient Safety Specialists, PSIRF leads, ICB, NECS, AHSN, NHSE regional, LMNS, AHSN.	Day/ time and frequency TBC
	To support national priority areas and local priorities that arise through PSIRF	
	Utilise a systematic QI approach & evidence based interventions	
Regional event planning	Event 2 – content TBC Workshops & webinars	?April / May TBC

NENC System Safety SIP

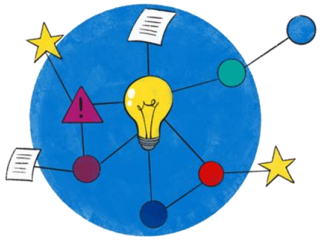




- FutureNHS workspace
- Links to events, webinars, workshops
- Links to other useful pages
- Forum available for regional discussions
- Useful documents

@PSSpecialistNE

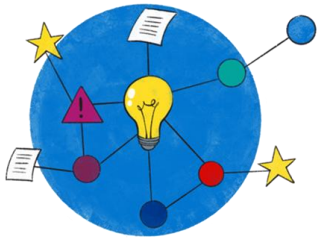
Purpose of the event



To bring together PSIRF implementation teams from providers and the ICB to share their learning from the early phases of implementing PSIRF and to work collaboratively on the upcoming phases of implementation, ensuring a regional approach to **learning from patient safety events**.

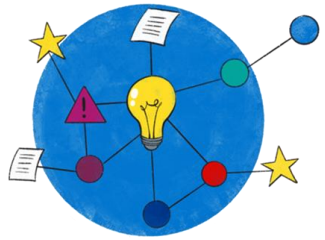
To embrace the spirit of PSIRF to ensure successful implementation.

Today's Objectives



- To provide the opportunity for networking and sharing good practice across providers / ICSs
- To support the implementation of the Patient Safety Incident Response Framework (PSIRF) across the North East and Yorkshire regions
- To share knowledge, insight and experiences to help support our teams
- Provide a space for each ICS / provider to focus on where they are now in the implementation of PSIRF and what their next actions need to be (focusing on governance & oversight)
- Share what support is currently available from National and Regional teams and discuss and identify what support ICS's / providers need for upcoming phases

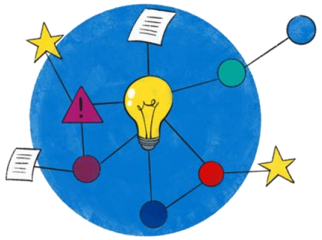
What next?



Is there an appetite for future events / sessions?

- Preference for face to face / virtual? Location? Size of venue?
- Full day? Half day? Presentations? Teaching / coaching sessions?
- Service specific events (MatNeo, MH, etc)?
- Topic ideas (examples)
  - PSIRF – a QI approach? Tools & techniques to support large scale change
  - Systems based investigation vs RCA – what's different?
  - Investigation or Review? What is a ‘proportionate response’? Is the output appropriate?
  - Aggregated data, thematic reviews and Trustwide improvement plans / frameworks
  - Engaging patients & families / recruiting PSPs
  - Engaging staff & psychological safety
  - Just Culture, Duty of Candour & Restorative practice

Thank you



To all of you for your participation, and to ….

Presenters

- Karen Conway
- Tracey Herlihey & Lauren Mosely
- Angela Edmunds & Richard Gibson
- Kate Jones
- Gemma Louch
- Maureen Grieveson

AHSN team

- Comms / event planning - Sarah
- PSC team - Julia, Emily, Divya & Ellie
- PSOs - Yoyo & Phil

NECS team

- Lorraine, Gregor, Claire & Alison

…and the AV team who made it all happen!

That's all Folks!