Norfolk and Suffolk NHS Foundation Trust’s Sign up to Safety Plan

Background

In October 2014 Norfolk and Suffolk NHS Foundation Trust (NSFT) signed up to the National Sign up to Safety campaign to demonstrate our commitment to continuously drive forward improvements in patient safety. The key areas of priority are contained within the safety improvement plan, which outlines six key areas of focus for NSFT over the next 3 years.

Delivering high quality care is at the core of services delivered within NSFT with the expectations that services delivered will be safe, effective and responsive to service users’ needs resulting in positive experiences based on compassionate care, underpinned by the following:

‘Patient Safety- The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, that patients shouldn’t fear violence, and that avoidable errors such as drug errors are minimised ‘
High quality care for all’: Lord Dazi. High quality care for all. DOH 2008

The Sign up to safety campaign supports the ambition of the Secretary State for Health of halving avoidable harm in the NHS over the next 3 years. The campaign aims to incorporate three key principles to improve patient safety:

- Listen - to patients/carers and staff
- Learn - from what they say when things go wrong
- Act – take action to improve patient safety when things go wrong.

Signing up to Safety enables NSFT set out a 3 year safety plan which links in with existing quality improvement plans and initiatives to continually measure and monitor the safety of services and seek out improvements in safety, supporting the organisation to build a learning culture that promotes and share’s excellent practice. The safety improvement plan and ambitions further support NSFT’s commitment to quality in that they support the structure of the 5 domains of the CQC:
• **Safe Services**
  1. Reducing avoidable harm—such as assaults, falls
  2. Reducing restrictive practice
  3. Embedding learning within services to prevent future incidents

• **Caring Services**
  1. Improve patient experience by providing safer environments and services
  2. Listening to service users and cares when things go wrong and act on the feedback
  3. Creating open and transparent culture whereby individuals feel safe to raise concerns

• **Effective Services**
  1. Continuous monitoring of measurable safety outcomes across services providing opportunities to share best practices

• **Responsive**
  1. Continuous improvements arising from learning supporting the development of a learning culture and organisation

• **Well Led**
  1. Supports a culture that encourages staff to have the ‘freedom to speak up’
  2. Understands and measures the quality of its services and ensures identified risks are managed

By making the commitment in Signing up to Safety NSFT will:

• **Put safety first**—committing to reduce avoidable harm within NSFT making both the safety goals and plans available to the public
• **Continually learn** from safety incidents and share that learning to prevent similar occurrences—by developing a culture of learning and development that strengthen NSFT’s ability to safety and risk.
• **Promote an open and honest culture** for those who work in our services and use our services—by being transparent with both those who use our services, work in our services and supporting people if something goes wrong.
• Collaborate - with services and teams to ensure learning is shared
• Provide support to individuals to understand why things go wrong and how to put them right and also celebrate improvements

The aim of NSFT's Safety Improvement Plan

The safety improvement plan sets out NSFT’s plans for the next 3-5 years in relation to safety and quality. This will help the Trust be clear about what it wants to achieve and how it will get there. The plan links with NSFT’S Quality Improvement Plan and with National Drivers in improving safety and transparency within the NHS, including:

• The NHS outcome Framework
• High Quality Care for all
• Positive and Proactive Practice – the need to reduce restrictive interventions DOH 2014
• The 6 C’s
• CQC Standards
• Duty of Candour

In providing a 3-5 year safety improvement plan NSFT aims to ensure that the improvements made will be sustainable and embedded in practice. It additionally demonstrates a long term commitment to improving safety. The main aims of the improvement plan are

• Provide clear and achievable initiatives that result in patient safety improvement initiatives
• Make a clear commitment in turning areas of improvement into practice
• Engage local teams, services, staff and those who use our services in developing local improvement plans.
• Make public our plan and regularly update on the progress made against it
Objectives

1. That safety is on the top of everybody’s agenda
2. For patient and staff experience to improve within safe caring environments
3. To implement a systematic approach to improving safety across NSFT to prevent harm and reduce incidents reoccurring
4. That NSFT embeds a learning culture that utilises existing and new information, experience and engagement of all involved in delivering services
5. To be able to demonstrate and share improvements

Improving the Safety Culture within NSFT

Patient Safety is central for all staff who delivers frontline services and a top priority for NSFT. NSFT recognises that while there are a number of existing systems and processes to share learning from incidents, this learning may not always be shared effectively to frontline staff in all areas. If frontline staff are not made aware of the learning from incidents, or the reasons behind changes there is an increased risk of the learning being lost with limited sustained impact on practice.

The monitoring of the outcomes from the ambitions and actions set out within the safety improvement plan will take place through the Quality Governance Committee (QGC) which is chaired by the Chair of NSFT and is a subcommittee of the Trust Board. The lead for Sign up to Safety will be the Director of Nursing, supported by the Deputy Director of Nursing. The Chief Executive is committed to the Sign up to Safety campaign and will have continued oversight of the progress made.

NSFT has a positive baseline from which to work from. It is a high reporting Trust and is within the country’s top 20% Mental Health Trusts for reporting incidents. This is an indicator of an open reporting culture. Key to patient safety is to support and thank staff that, continue to raise questions about safety via incident reporting. Engagement, learning and feedback is central in further development of a proactive safety culture.
The 5 Safety Priorities

The Trust has identified 5 key initiatives to improve safety and have set the following ambitions for each of the priorities:

- Reduce the number of Restrictive Interventions used within NSFT by 25% by 2018
- Reduce the number of assaults by 25% within NSFT by 2018
- That no falls result in severe harm.
- Provide an environment that reduces the risk of harm so that all inpatient areas comply with current Same Sex accommodation standards and free from risk of ligature.
- To ensure the Trust embeds a safety culture based on openness, transparency and learning from previous incidents that have caused harm. So that individuals feel supported and safe to report incidents and when things go wrong and improvements are made to prevent future occurrence.

The safety improvement plans for each of these ambitions have been developed and align and cross reference to NSFT’s Quality Improvement plan (QIP), and identify specific goals for years 1-3. The plan also includes actions to achieve the required goals and how these goals will be measured and progressed. While there is clear commitment drive and energy to achieve the ambitions the reality is that there will still be situations where things may go wrong, NSFT commits that in these cases we will continue to utilise these experiences to learn and continuously improve services.
Review of Current Reporting Activity

NSFT has a positive reporting culture and reports approximately an average of incidents 1358 a month and is consistently within the top quartile of Mental Health Trust reporting incidents via the NRLS system. All reportable incidents are recorded via the risk management system datix, the system is configured to ensure that the appropriate clinicians and managers review incidents and provide feedback to the reporters.

All serious incidents (SI’s) are reported to commissioners in accordance to the NHS England Serious Incident Framework 2015 via the Strategic Executive Information System (STEIS).

Incidents from both reporting systems are uploaded to the National Reporting and Learning System which provide opportunities for benchmarking across Trusts. When incidents occur it is important that lessons are learned to prevent further incidents and harm. By monitoring themes and trends improvement plans can be created and actioned to prevent further occurrence.

Annualised data activity for future benchmarking

Restrictive Interventions

During 2014 – 2015, the total number of reported restrictive interventions was as follows:

- Restraints 2600
- Prone Restraints 850
- Seclusions 730
The Graph below demonstrates the use of restraint across all localities and services and have been reported against the National Guidance for the reporting of restraint. Any restrictive intervention involving direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Total restraints in NSFT, April 2014 – March 2015

To support the implementation of Positive and Proactive care NSFT has reviewed its data from the reporting year April 2013-14 to establish a benchmark of which to establish a 25% reduction in the use of restraint within NSFT during the next 3 years. The data produced and future data will be scrutinised via the existing Patient Safety Group and Positive and Proactive implementation group for emerging trends. Both of these groups have attendance from staff across services and localities to ensure consistency in measurement and reporting is in place as well as sharing of practice.
Training in the accurate reporting of prone restraint and seclusion is ongoing in line with The Mental Health Code of practice, it is expected that numbers may increase in the short term as clearer understanding of reporting is established across NSFT. And will be monitored by forums described above.
Physical Assaults
The below graph demonstrates the total number of physical assaults that have occurred within NSFT during the reporting year April 2014- March 2015.

The physical assaults shown relate to all levels of assault to staff, service users and others within the Trust during April 2014-March 2015, lessons learnt are shared with the Patient Safety Group, Health and Safety Committee and Trust Board to reduce the risks in the environment and support clinical best practice when undertaking patient risk assessments. As can be seen from the graph a majority of these events occur in Older People’s services, Specialist Services (Learning Disabilities) and Secure Services (including Forensic Services).
Assaults impact on the effects of a service users experience and staff sickness levels and remains therefore a priority of the Trust to support wellbeing, engaging with staff and service users post incident and ensuring appropriate support is given and focus on prevention creating a safe working environment supporting staff in minimising actual assaults and impact.

Falls resulting in Harm
The following graph sets out the level of harm arising from falls in the year April 2014 – March 2015. Falls are a major concern for patient safety and a marker of care quality. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per year in immediate healthcare treatment alone (NPSA, 2007)
The Trust has measures in place for reviewing all falls and whilst the Trust level of harm remains low (33) moderate or above out of 381 events in 2014-2015 our services in older people Central still have higher levels than similar ward /care environments on other Trust premises. The Trust has a number of measures in place in preventing and managing falls, which are balanced with patients’ rights to dignity, privacy, independence, rehabilitation and their choice about risks they are prepared to take in agreement with carers and clinical teams. Fall preventions forms part of the core training in place for clinical and non-clinical staff within the Trust and support falls reduction and the reduction in the levels of harm to patients in our environment.

![Total Falls with Harm 2014/15](chart.png)

**Current Position for Environmental Safety**

**Anti-Ligature**

The Health and Safety Executive (HSE) is responsible for enforcing the Health and Safety at Work Act 1974 (HSWA) and associated legislation throughout Great Britain. As a national regulator it aims to reduce death, injury and ill health by securing the health, safety and welfare of workers and protecting others, such as contractors or patients, who may be affected by work activities. Whilst HSE focuses on the health and safety of employees, their role in patient safety under section 3 of HSWA, states: "It shall be
the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

Three-quarters of people who kill themselves while on a psychiatric ward do so by hanging or strangulation.1 A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature points include shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.

The Trust has responsibility of Medium Secure, Acute, Older People and Learning Disability Services for 29 in-patient wards over five sites throughout Norfolk and Suffolk. The Trust recorded 2 suicides by means of a ligature point in 2014/15 and 18 near misses, where a patient had attempted to tie a ligature to a fixed point within the environment which was identified and stopped by staff.

Work with Estates and Clinical teams to ensure that known ligature are reduced or removed and that learning from events mean that any new ligature risks are dealt with in a timely and appropriate manner.

Line of Sight

The Care Quality Commission (CQC) visit in October 2014 identified a number of environmental safety concerns, stating ‘While some work was being planned or underway to remove potential ligature risks, we are concerned that planned actions would not adequately address all issues. We also found that the layout of some wards did not facilitate the necessary observation of patients.’

The Trust’s annual audit addressed the use of mirrors and CCTV to reduce risks in patients undertaking self-harm or at increased risk of being unobserved for any significant period within the risk management of the patient and the environment. A programme of CCTV upgrades and use of parabolic mirrors are put into place.

Same Sex accommodation

Same-sex accommodation means patients and service users share sleeping accommodation, bathroom and toilet facilities only with people of the same-sex. It applies to all areas of hospitals and mental health units.
It is delivered by:

- same-sex wards (i.e. the whole ward is occupied by either men or women but not both)
- single (bed)rooms with adjacent same-sex toilet and washing facilities (preferably en-suite)
- same-sex bed bays or (bed)rooms, with designated same-sex toilet and washing facilities, preferably within or adjacent to the bay or room.

Service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own facilities.

Organisations are required to provide women-only lounges in new and refurbished buildings.

The Trust identified the need for additional lounges to comply with these regulations on Woodlands site in Ipswich. Whilst other sites have systems in place to manage this risk, ongoing monitoring remains in place to ensure changes do not increase non-compliance.

A programme of works to address the wards at Ipswich has commenced.

Creating a Culture of Safety and Learning

Creating a culture of safety & learning is critical to ongoing service development, patient experience and safety. Learning from previous events both internally to the Trust and externally provides an evidence base. Sharing and embedding this learning is a
significant stage which requires consideration and resource. Research demonstrates there are various means by which learning is embedded into a system, of which communication is one.

Alongside internal reflection, the feedback from the Care Quality Commission inspection in February 2015 informed the Trust there was limited evidence of frontline staff having an understanding of learning from a range of sources such as serious incidents, complaints and incident reporting.

Considering this feedback, within the Trust’s Quality Improvement Plan a work stream was created to develop and apply activity to improve the communication of learning.

**Actions**

The Sign up to safety campaign will be supported and underpinned by NSFT’s QIP, to deliver the ambitions we will need to

- Work collaboratively across all localities and services both operational and corporate functions
- Review and monitor data and reporting systems and monitor improvements against the key ambitions and priorities
- Ensure sufficient resource and capacity is available in the context of the competing pressures and priorities within NSFT.
- Create space and time to implement models of change both practical and reflective to develop learning on patient safety initiatives and what went well or could have gone better.
- Continue to create and support shared ownership and accountability by working collectively across services, localities and professions
Safety Improvement Plan

Norfolk and Suffolk Foundation Trust is committed to improving Patient Safety and deliver safe effective care. In order to support the delivery of safe care we have identified 5 key areas that support staff and services to deliver safe care and also support the delivery of NSFT’S Quality Improvement Plan. The five key improvements identified within the improvement plan below have been identified as a result of a number of combing factors including, Incident reporting, serious incidents and lessons learnt and combines environmental, clinical and cultural changes within the organisation to support patient safety. The safety improvement plan is an integral part to NSFT’s Quality Improvement plan arising out of the CQC report received in February 2015 which in turn provides a framework for the delivery of the Safety Improvement plan.
<table>
<thead>
<tr>
<th>What do we want to achieve</th>
<th>What is our goal</th>
<th>How will we measure the improvement</th>
<th>What we need to do to make it happen</th>
<th>Leads</th>
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| In line with both the 2014 DOH guidance Positive and Proactive Care reducing restrictive interventions and the principles of Recovery NSFT aims to provide services that are both safe and therapeutic placing service user choice and involvement at the centre all we do | NSFT has committed to reducing the use of restrictive intervention within NSFT by 25% by 2018. Data collected during the reporting year 04/14 03/15 records the following physical interventions as Restraints 2600 Prone Restraints 850 Seclusions 730 | By establishing a baseline of current use of physical interventions within NSFT to monitor progress. By developing an understanding of the data and how it informs practice, and using that data effectively to support the reduction of physical interventions. By regular monthly monitoring of the reporting of incidents related to physical interventions, identify any early trends or themes which will enable teams to be supported during challenging episodes of care. With the use of audit we will monitor the use of interventions such as seclusion and benchmark across services. Via service user feedback | Collect data across the reporting year April 2014 – March 2015 as a benchmark. Utilise the data to share across NSFT to support both PMA team and clinical services to understand and share current practice. This will happen via a number of actions • PMA team to establish clinical links into services to support teams • Regular monitoring of incident reports picking early indicators of challenging and complex presentations that PMA team can support services with. • Share that data within supported forum for Clinical team leaders to share practices across NSFT. With the aim of areas using higher levels of interventions can work with peers in matched clinical areas to share practice. This includes incident reporting and audit. • Reintroducing rotational instructors to embed local champions skilled in de-escalation behaviours • Support cultural change via Safe wards roll out and introduction of positive behavioural support plans via the Recovery College • With the roll out of Safewards | Deputy Director of Nursing  
PMA lead  
PMA lead and Patient Safety team  
PMA lead and Clinical Team Leaders  
Matrons and Deputy Matrons with CTL |
<p>| That all service users are cared for in environments that do no harm and that harm is avoided in those most vulnerable and at risk groups of service users feel safe and supported in our services. | Reduce the number of physical assaults by 25% within NSFT by 2018 resulting in harm | By establishing a baseline of existing data and level of harm reported as physical assault within NSFT to monitor progress. By developing an understanding of the data and how it informs practice, and using that data effectively to support the reduction of physical assaults. By regular monthly monitoring of the reporting of incidents related to physical assaults, identify any early trends or themes which will enable teams to be supported during challenging episodes of care. Via service user feedback | Collect data across the reporting year April 2014 – March 2015 as a benchmark. • Utilise the data to share across NSFT to support both PMA team and clinical services to understand and share current activity and establish any patterns of behaviours. • Adoption and roll out of Safewards as an evidence based model designed to reduce conflict and containment with Mental Health settings. • Regular monitoring of incident reports on a monthly basis via the patient safety group meeting. The aim of this group will be to identify early indicators of challenging and complex presentations. • By ensuring staff have the skills to risk assess and plan care that supports reduction of violence in those with known history of physical assault or at risk of physical assault | Involvement and engagement | Deputy Director of Nursing Via Patient Safety team, PMA lead and CTL’s | Matrons, Deputy Matron’s and CTL’s | Patient safety Lead | Practice skills Educators, Recovery College and Patient Safety team |
| That all service users are cared for in environments that do no harm and that harm is avoided in those most vulnerable and at risk groups of service users such as those with physical fragility at risk of falling | That no falls result in severe harm. | By establishing and analysing the current trend data in relation to falls resulting in harm with reference to team and circumstances. By using the data set to monitor falls with severe harm on a team and location basis each month. By presenting the data for scrutiny and analysis, monitoring and acting upon trends. | • Ensure the falls and related policies are kept updated in response to new national guidance and local learning. • Ensure training is completed via e-learning module for relevant clinical staff. • Audit completion of falls risk assessments on a regular basis and take action where this falls below standard. • Ensure Datix reports questions, which contribute towards the understanding of the circumstances of the fall to support a root-cause analysis (RCA), are completed at the time of signing off the report – modify these questions as necessary | PMA team, Matron’s and Deputy Matron’s. Service Managers PMA Lead and Training Manager | Trust physiotherapy lead / Physical health team Locality managers Audit team / local teams CTLs / Datix team |</p>
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<th>Task</th>
<th>Responsible Parties</th>
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<tr>
<td>Prepare data from Datix reports to demonstrate trends across services for the preceding year.</td>
<td>Datix team and Physical Health team</td>
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<td>Ensure local learning is taken from completion of the Datix reports and RCA questions within this.</td>
<td>Ward managers / CTLs</td>
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<td>Use current action plan which has been developed from RCA information over the preceding years. Continue to update this action plan in response to further learning from incidents.</td>
<td>Physical Health team</td>
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<td>Ensure the action plan is available for review at relevant meetings and forums eg the Physical Health Forum for locality physical health links, locality PH meetings</td>
<td>Meeting leads</td>
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<td>Provide an environment that reduces the risk of harm so that all inpatient areas comply with current Same Sex accommodation standards and free from risk of ligature.</td>
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<tr>
<td>1. That all inpatient areas minimise the risk of ligature by providing as far as possible ligature free environments</td>
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<td>2. That all inpatient areas comply with same sex standards in line with national regulation</td>
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<td>By establishing a baseline of current identified ligature risks within NSFT to monitor progress.</td>
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<td>By developing an understanding of the data, learning from other reported incidents or near misses and how it informs practice, and using that data effectively to support the</td>
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<tr>
<td>Collect data across the reporting year April 2014 – March 2015 as a benchmark.</td>
<td>Risk Manager and CTL</td>
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<tr>
<td>• Utilise the data to share across NSFT to support both Estates and clinical services to understand and share current activity and establish any emerging risks.</td>
<td>Meeting with CTL’s, Risk Management, and Estates department</td>
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<td>• Adoption and roll out of programme</td>
<td>Estates manager</td>
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<td>To ensure NSFT embeds a safety culture based on openness, transparency and learning from previous incidents that have caused harm. So that service users, carers and staff feel supported and safe to report incidents and when things go wrong and improvements are made to prevent future occurrence.</td>
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<td>That NSFT is recognised as an organisation that supports individuals to raise concerns and that learns from those things that do go wrong and changes practice to avoid repartition.</td>
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<td>NSFT currently reports incidents via national guidance and reports incidents via Datix and Serious Incidents via the National reporting system STEIS. In line with new legislation NSFT also adheres to guidance set out in the Duty of Candour. NSFT is consistently in the top quartile of trusts reporting into the NRLS with a history of high reporting</td>
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<td>• Make sure safety is at the top of everybody's agenda. NSFT will embed standard agendas across teams and services to make sure quality and safety is cascaded consistently across the organisation. Minutes of meeting will be audited to ensure standard template is consistently used with key messages on every locality and team meeting.</td>
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<td>• Lesson learnt reports will be received monthly by NSFT’s Quality Governance Committee (QGC) and shared with all localities and Service</td>
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<tr>
<td>Datix /Risk Management team Patient Safety updates</td>
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<th>reduction of ligatures. By regular monthly monitoring of the reporting of incidents related to ligatures, identify any emerging trends or themes which will enable teams to be supported during challenging episodes of care. With the use of audit we will monitor the use of interventions such as seclusion and benchmark across services. Via monthly audits and incident reporting.</th>
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<td>of priority works (scored 12+) designed to reduce in environment in Mental Health settings.</td>
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<tr>
<td>• Regular monitoring of incident reports and spot audits on a monthly basis. By ensuring staff have the information and skills to risk assess and plan care that supports reduction of risk of undertaking ligatures and to identify early triggers</td>
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<tr>
<th>Deputy Director of Nursing</th>
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<td>Patient Safety Lead and Chair of QGC</td>
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with low incidents of harm, indicating a open safety culture. SI investigations are conducted in line with National standards using Root Cause Analysis and reports are shared with families. NSFT also has a rising concerns line that is overseen by the safeguarding team. These current reporting systems provide us with accurate data to compare year on year activity. As an organisation NSFT does appear to have recurring themes linked to SI reports and while systems are in place delivering key points of learning to clinical services and frontline staff can be challenging, to measure if learning is embedded the actions undertaken will be closely monitored and audited to demonstrate and improvement in NSFT’s organisational learning.

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<td>leads, an assurance process to ensure learning is cascade and embedded. This will be followed up by random audit.</td>
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<td>• Lesson learnt will form part of Board Reports on safety and quality to ensure organisational awareness and understanding of key issues.</td>
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<td>• Staff will regularly and consistently receive learning from incidents and complaints via existing channels and forums. This learning will be made up of the patient safety intranet page, newsletters, articles in NSFT publications and updates, presentations to key forums such as Leadership forum and acute services forum, and aide memoirs. The delivery of this information and its effective use will form part or NSFT quality improvement visits and experience feedback exercises.</td>
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<td>• Dedicated learning and development sessions with teams based on learning and trends within RCA reports, these maybe service specific or team specific.</td>
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<td>• Delivery of organisational training related to learning and emerging themes from incidents eg DICES risk training which will be delivered locally into clinical teams.</td>
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Deputy Director of Nursing

Patient Safety Team supported by Communication team

Patient safety lead supported by Patient safety team.
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<th>Training Department and Service managers supported by Matrons</th>
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<td>Appointment of new quality posts to support staff in the clinical environment with learning and development using lesson learnt as a central part of service development, including Deputy Matrons and Clinical skills educators.</td>
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<td>The patient safety team will support teams to embed learning by utilising new process and methodology including Human Factors.</td>
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