Patient Safety Incident Response Plan

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Cromer Hospital

Sept 2023 – 2025 v1

Our Values People focused Respect Integrity Dedication Excellence

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Foreword from our Associate Director of Quality and Safety

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

PSIRF is ***very different***. Unlike previous frameworks, PSIRF is not a tweak or amendment of what came before but a whole system change to how we think and respond when an incident happens to prevent recurrence. The previous Serious Incident Framework mandated when and how to investigate a serious incident whereas PSIRF focusses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles which we need work to but outside of that, we determine what we will investigate and how.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

When asked why we investigate incidents, the common response is to learn from them. Often, we mean learning as understanding what has happened, but it should be much more than that. How much has changed/improved in 20 years using this approach?

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological resolution for those involved are all core objectives of an investigation.

The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak up. PSIRF is a core component in this journey, ensuring we create a psychologically safe culture where people are confident to speak candidly about patient safety events and to simply express their opinion.

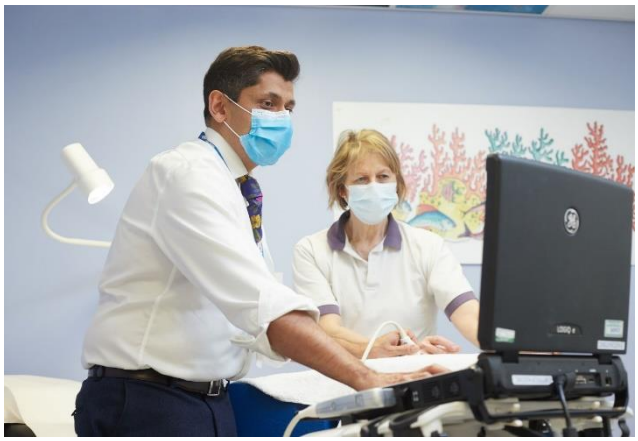
A group of organisations have already implemented this process as early adopters and thanks to them we already know much more about how this new approach works. However, each organisation is different, and we may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF, we will talk and respond, adapt as and when our approach is not achieving what we set out to achieve.

Thank-you for being part of this new way of working and we are excited to work in a new way together to really make a difference to the safety of care delivered to our patients.

Karen Kemp
Associate Director of Quality and Safety

An introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), which replaces the NHS Serious Incident Framework. This document is our Patient Safety Incident Response Plan (PSIRP). It sets out how we intend to respond to safety incidents.



The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. 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 in a small number of areas of highest patient safety risk for us as organisation. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associated policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify new insight and learning. Removal of the serious incident process does not mean “do nothing”, it means respond in a proportionate way depending on the type of incident and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new name. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is a psychologically safe culture shown in our leaders, our Trust-wide strategy and our reporting systems.

We have developed our understanding and insights about our patient safety profile over the past two years. In April 2023, the Clinical Safety and Effectiveness Sub-Board and the Quality and Safety Committee received and supported the thematic situational analysis and highest patient safety risks that informs our local priorities for PSIRF. This plan provides the headlines and description of how PSIRF will be applied in Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust).

The scope of PSIRP and our vision

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems- based learning and improvement.

There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims or inquests.

This plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

There are four strategic aims of the PSIRF upon which this plan is based.

The strategic aims are aligned with our own Trust vision and purpose statements. The Trust's vision statement is:

"The best care for every patient"

Our Purpose is:

"Working together, continuously improving for all"

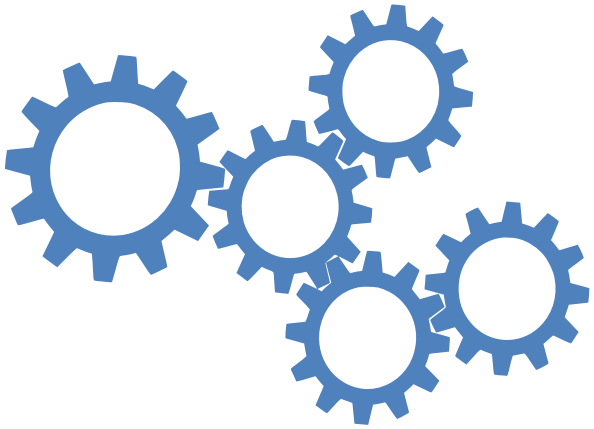
The implementation of PSIRF will see the strategic aims and our Trust values embodied in our work.

Trust Values	People focused	Respect	Integrity	Dedication	Excellence
PSIRF Strategic Aims	Improve the experience of care by patients,their families and carers, by improving the safety of care delivered	When a patient safety incident, or need for a PSII is identified, we will keep staff, patients, their families and carers at the centre of the investigation & learning process	Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations	Equip patients, staff & partners with the skills & opportunities to improve safety throughout the whole system	Improvement programmes enable effective and sustainable change in the most important areas

System overview of Norfolk and Norwich University Hospitals NHS Foundation Trust

We reviewed our local system to understand the people who are involved in patient safety activities across the Trust, as well as the systems and mechanisms that support them. The Trust is a centre of excellence for health care in the East of England in several fields as well as one of the largest University teaching Trusts in the country. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

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



This Trust has several Corporate Departments working alongside each other providing support to the Clinical Divisions; The Risk and Patient Safety Team, the Patient Experience and Engagement Team, Quality Improvement team, Transformation Team, Complex Health Hub, Organisational Development and Legal Services.

There are 4 Clinical Divisions consisting of Medicine, Women and Children, Surgery Critical and Emergency Care, and Clinical Support Services.

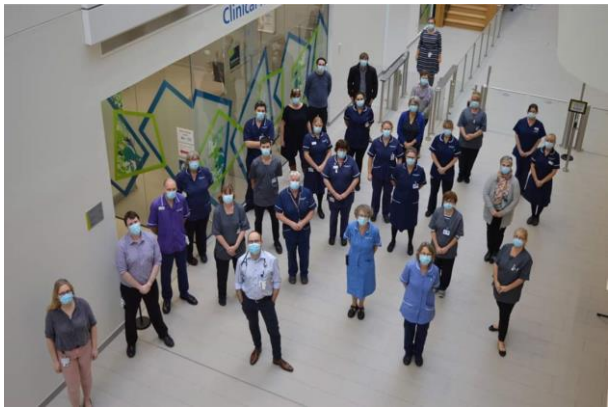
Core patient safety activities undertaken at the Trust include:

- NHS Patient Safety Strategy
- Patient Safety Culture
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Supporting improvement programmes

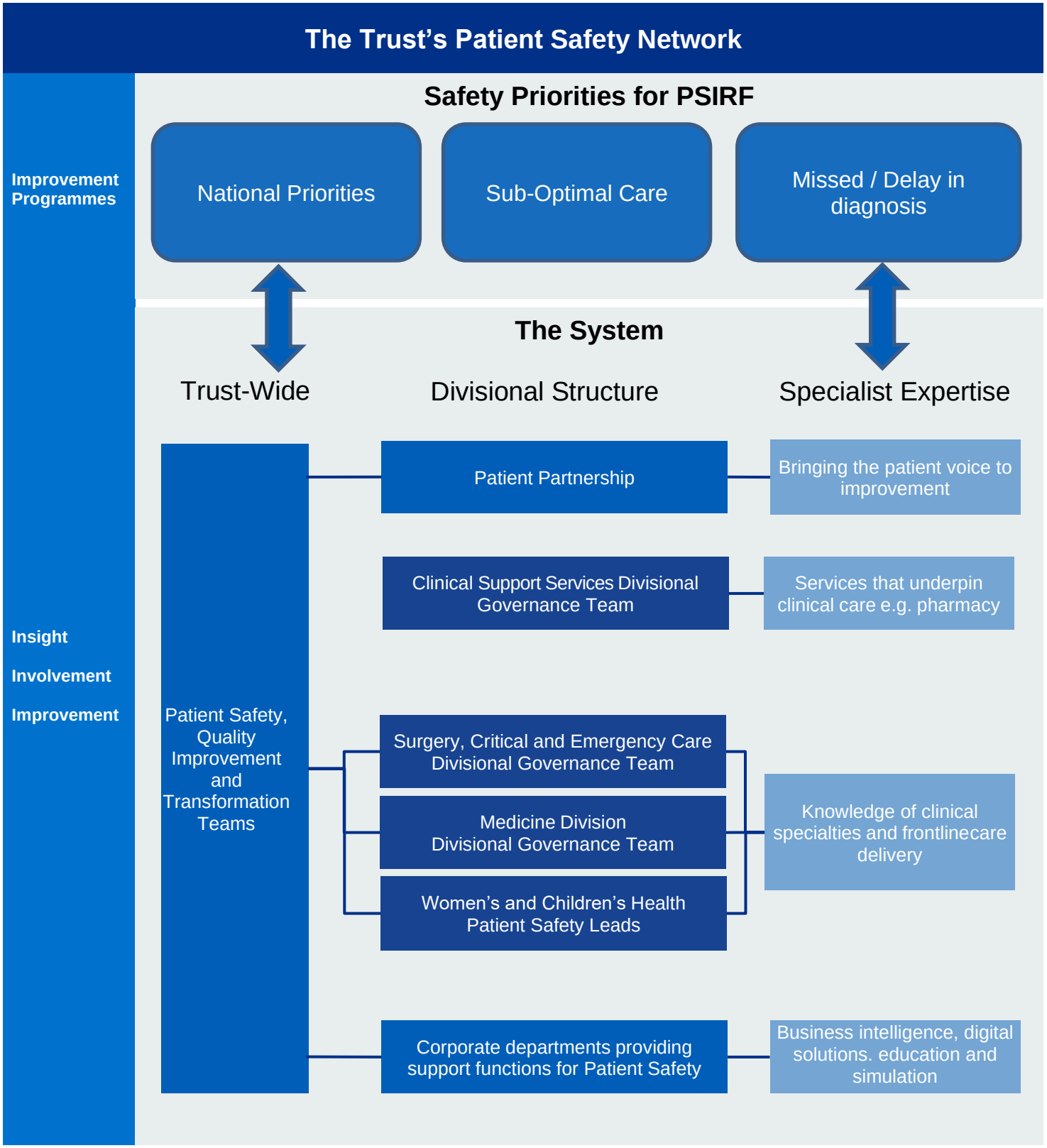
Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews (SJR), Learning from Deaths, complaints and feedback, claims and inquest responses.

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

This ‘Patient Safety Network’ involves key people and teams within the Trust who are integral in facilitating our patient safety system and patient safety culture to implement and embed PSIRF.



System overview – our networks



Situational Analysis of Patient Safety Activity

In the last four years, more than 109,000 patient safety incidents have been reported in the Trust with less than 0.7% of these being investigated as a Serious Incident under the Serious Incident Framework.

A large portion of the work our Divisional Governance colleagues undertake in is serious incident investigations. These can be a very time- consuming process.

There is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99.3% of patient safety incidents. In short, the burden of effort is placed on fewer than 0.7% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as possible as we did within Serious Incident Framework but simply calling them something else.

A key part of developing the new national approach is to understand the amount of patient safety activity the Trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, systems and processes to support the new approach.

The patient safety PSIRF related activity undertaken prior to PSIRF can be broken down as follows:

Patient Safety Activities	Activity	Definition	Average of previous 3 financial years	Last financial year
National Priorities	Incident resulting in death	Serious incident requiring investigation which met the standard investigation timeframe and resulted in patient's death.	23	21
	Never Events	Incident meeting criteria for never events framework and reported to STEIS as an SI	5	4
Local Patient Safety Activities	Serious Incident Investigation (SI)	Serious incident which met the standard investigation timeframe.	207	216
	Patient Safety Reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SI criteria	392	142
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring investigation at department/ward level.	25721	15091

Thematic analysis and our ongoing patient safety risks

We conducted a thematic analysis, to identify our highest areas of patient safety risk to identify our priorities.

Our analysis used additional sources of patient safety insights, beyond that of incidents which resulted in severe harm or death. The initial thematic review looked at patient safety activity between April 2018 and March 2021.

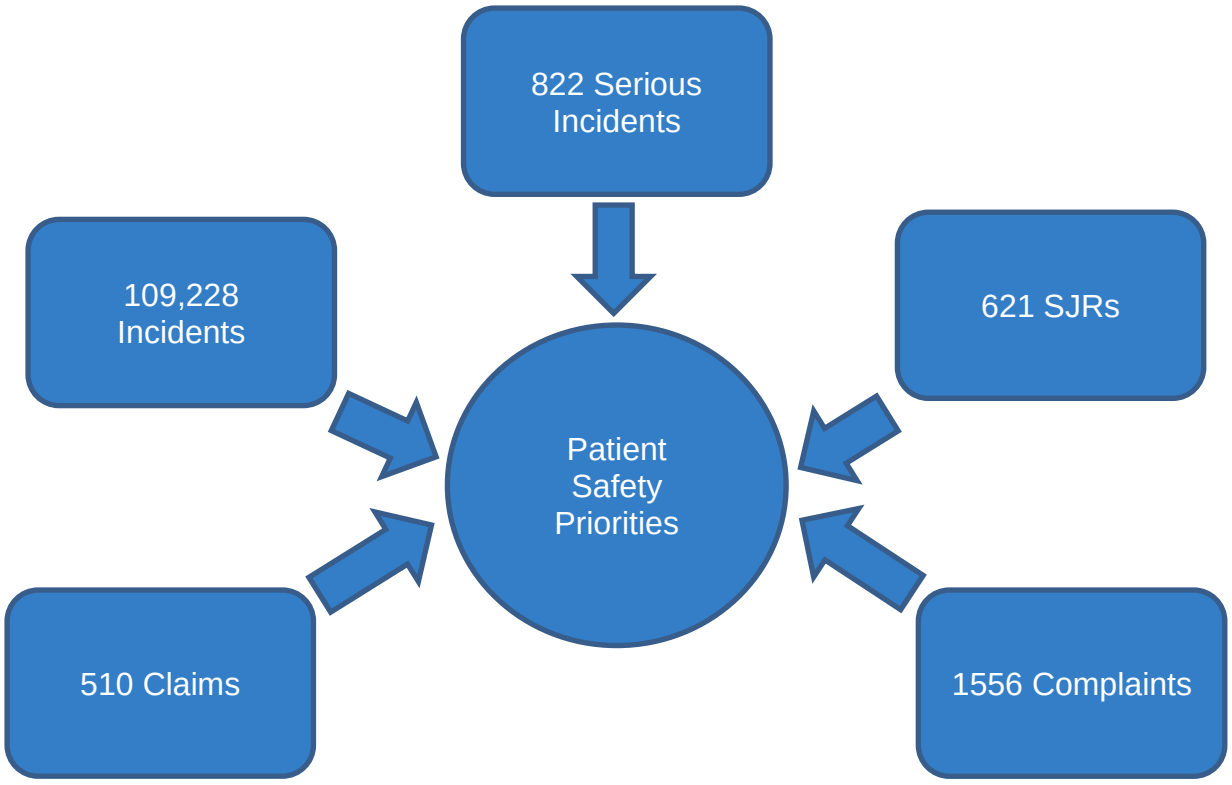
The priorities identified throughout this analysis validate what has been seen throughout patient safety incident reporting for many years. As locally defined priorities, PSIRF allows us to focus on these risks with our framework for patient safety incident response.

As the national implementation of PSIRF was paused for a year whilst the National Patient Safety Team undertook a review of the 23 early adopter sites, the reported incidents and SJRs for April 2021 to March 2022 were reviewed to ensure that there were no new emergent risks.

We have developed patient safety recommendations overleaf which are based on both the original thematic analysis and the updated incident review.

Sources of insights from this analysis included:

1. Serious Incidents Requiring Investigation (SI)s. Including Falls and Pressure Injuries.
2. Patient Safety Incidents reported including all no, low or moderate harm incidents
3. Structured Judgement Reviews
4. Trust Claims scorecard 2011 – 2021
5. Complaints received relating to clinical care and treatment



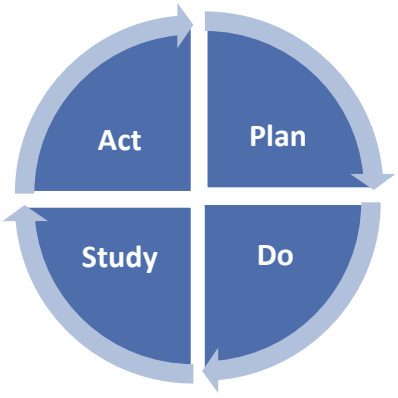
Our Patient Safety Priorities

Through our analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, we have determined 2 patient safety priorities we will focus on for the next two years.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews.

The patient safety priorities were agreed at the Quality & Safety Committee in April 2023.

Theme	Key Theme	Key Risks from Activity
1	Missed/ Delay in Diagnosis	Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment. This was the 2nd highest reported Serious Incident and the top incident resulting in lower level of harm. It was also identified as a theme in complaints, SJR and claims.
2	Sub Optimal Care	Incidents affecting patients where care is being managed between >1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation. This was the 4th highest reported Serious Incident and featured in the top reported incidents resulting in lower levels of harm. It was also identified as a theme in complaints and Structured Judgement Reviews.



Falls and Pressure Ulcers were in the highest 4 incident categories reported from the analysis. However, we already understand the contributory factors well and these are already part of active improvement plans which are being monitored to determine efficacy, so they have not been selected as a priority for PSII.

How we will respond to patient safety incidents

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is tofacilitate an approach that involves decision making through a multi -professional approach to commission investigations and receive findings and recommendations.

At the onset, we will use existing structures to support the process of decision making. There is an established daily meeting at which incidents reported as moderate harm or above are reviewed, and potential serious incidents are discussed. This meeting is presently called the Serious Incident Group (SIG) and is a Trust wide meeting. For PSIRF, we will change the name and purpose, to Daily Incident Triage and this will be held daily within each Division.

As we transition into PSIRF, the Patient Safety team will continue to work closely with the Divisional Governance teams to review and identify incidents that may require a patient safety incident investigation. In PSIRF, the approach of greater than or equal to severe harm will no longer apply, and we will be guided by the national and our local patient safety priorities.

The process will be described in detail in the associated policies, particularly in new policies that describe Patient Safety Incident Investigations, Patient Safety Incident Responses and involving patients in discussions about incidents, learning and improvement.

Core to deciding what to investigate was the situational analysis. The analysis identified two Patient Safety Priority incident categories that learning will be structured against over the first 2 years.

National guidance recommends that 3-6 investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 33-39 investigations per year. Attempting to do more than this will impede our ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

Patient Safety incidents that must be investigated under PSIRF:

1. Patient safety incident is a Never Event
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
3. National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above. Any new priorities will be included as they emerge).

Patient safety incidents are events where a patient has or could have experienced harm as a result of a healthcare activity. An incident indicates that something is wrong with our systems and processes whether actual harm occurred or not. Therefore, it is important to look at all incidents regardless of level of harm.

How we will respond to patient safety incidents

Apart from the national criteria for PSII above, the decision to carry out a patient safety incident investigation should be based on the following:

- the patient safety incident is linked to one of the Trust's Patient Safety Priorities that were agreed as part of the situational analysis.
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Care Quality Commission (CQC) Regulation 20 says we must:

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

Patient safety incidents that have resulted in severe harm:

These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements and undertake a Patient Safety Review. This will both provide insights to thematic learning and provide information about the events to share with those involved.

How we will respond to patient safety incidents

	Incident	Approach	Improvement
National Priorities	Meeting Each Baby Counts Criteria	Refer to HSIB	Respond to recommendations made by external agency as applicable.
	All perinatal and Maternal Deaths	Perinatal Mortality Review Tool (PMRT) Refer to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	
	Child Death	Refer to Child Death Overview Panel (CDOP)	
	Death involving patient with Learning Disability	Reported and reviewed by Learning Disability Mortality Review (LeDeR)	
	Safeguarding	Refer to NNUH Complex Health Hub for Safeguarding review Safeguarding referral	
	Information Governance	Refer to Trust I.G. Lead for Data Security and Protection Toolkit review Refer to Information Commissioner	
	Incidents related to National Screening Programmes	Report to the Screening Quality Assurance Service (SQAS)	
	Deaths of patients in custody, in prison or on probation	Report to Prison and Probation Ombudsman	
	Incidents meeting Never Event Criteria	Statutory Duty of Candour PSII	Create local organisational recommendations and actions.
	Incidents resulting in death	Statutory Duty of Candour SJR ➡ If deaths more than likely than not due to problems in care ➡PSII	
Trust Priorities	Missed / Delay in Diagnosis	Statutory Duty of Candour PSII	
	Sub – optimal care	Statutory Duty of Candour PSII	
Local Level	Incident resulting in moderate or severe harm	Statutory Duty of Candour Patient Safety Review	Inform thematic analysis of ongoing patient safety risks
	Incident resulting in moderate or severe harm linked to an existing Quality Improvement Programme	Statutory Duty of Candour Validation of facts at local level	
	Incident resulting in low or no harm	Validation of facts at local level Thematic analysis	

Patient Safety Incident Investigations

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents.

Investigations analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors. We will no longer search for a single root cause; we will look at the different events that occurred leading up to the incident and analyse the possible causes. This supports us in looking at the system and not the people as individuals who work within it.

Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

The Trust will conduct PSII using the Systems Engineering Initiative for Patient Safety (SEIPS) Model to explore care system interactions and outcomes.

This approach includes a detailed investigation of the tools and technology used, tasks undertaken and the factors that influence the patient and staff involved. It also explores the internal and external factors impacting on systems and processes and how the work has been organised.

During 2022, the first staff completed investigation training using the SEIPS model with the Healthcare Services Investigation Branch (HSIB) and have now been equipped with knowledge and tools to support high quality investigations at the Trust in preparation for us going live with PSIRF.

An important Patient Safety Review methodology that the Trust will be using to review incidents at a local level will be After Action Review (AAR). AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the Multi-Disciplinary Team (MDT) and can be used to discuss both positive outcomes as well as incidents.

The first cohort of 32 staff have completed After Action Review Conductor training, with a further 9 undergoing a train the trainer course to deliver this to an increasing number of staff within the organization.

Maternity Incidents

In addition to the national level investigations, incidents for local level investigation will involve a multidisciplinary case note review and discussion of all incidents resulting in severe harm. This methodology will ensure a consistent approach and provide assurance that maternity incidents are being reviewed in a robust way to extract maximum learning. After Action Review will also be used for some incidents, where appropriate.

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

The patient voice is very much an integral part of our work at NNUH; we share below insights from the Chair of our Patient Panel who is also our first Patient Safety Partner, to explain our vision for PSIRP.

As the current Chair of the Patient Panel at the Trust and the newly appointed first Patient Safety Partner I am fully focussed on patients, families and their experiences whilst attending our hospital. We all strive to make these as positive and safe as possible but have to acknowledge that sometimes thing will go wrong. When this happens, it is vital that the voice of the affected patients and/or family members is heard loud and clear.

They are the ones with the lived experience, and this is so powerful. Adverse safety incidents can have life changing effects on the individuals concerned. It is therefore critical that their voices are brought to the table and heard with the same respect and value as those of our clinical colleagues. Time and time again you hear from patients that their primary concern is that what has happened to them will not happen again to another individual.

The hospital needs to be seen to be taking the appropriate action in learning from events and helping to prevent them in the future. As Chair of the Patient Panel, I lead a team of dedicated volunteers who are embedded in the hospital and sit on senior committees etc to ensure the patient voice is heard and represented at all times.

I hope to develop this work as a Patient Safety Partner and ensure we never forget why we are all here, to provide the safest treatment and care for all our patients and families and when this may regrettably go wrong to ensure they are at the centre of any investigations into their care and treatment. We are stronger together when all affected parties can communicate and share in a safe welcoming space.

Rosemary Moore
Chair, Patient Panel and Patient Safety Partner.

Involvement and support for staff following incidents

“Underneath every simple, obvious story about ‘human error’, there is a deeper, more complex story about the organization”

Sidney Dekker.

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

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

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a range of psychological wellbeing support for all staff. This includes but is not limited to:

- Local support from line managers, Human Resources and Workplace Health and Wellbeing
- Schwartz Rounds
- 24-hour telephone counselling advice line - INSIGHT 0800 0277844
- Inhouse legal department will support staff with witness statements and attendance at Coroners court.
- Professional Nurse and Midwifery Advocates

PSII is not the only tool we will use to respond to incidents. Our policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents.

We have outlined several ways we can respond to individual incidents; this includes but is not limited to:

After action review: A structured facilitated debrief.
SWARM huddle (proactive safety huddle or hot debrief): A planned team gathering to regroup, seek advice, talk about the event.
MDT Case note review

Mechanisms to support, evaluate and monitor improvements following patient safety investigations.

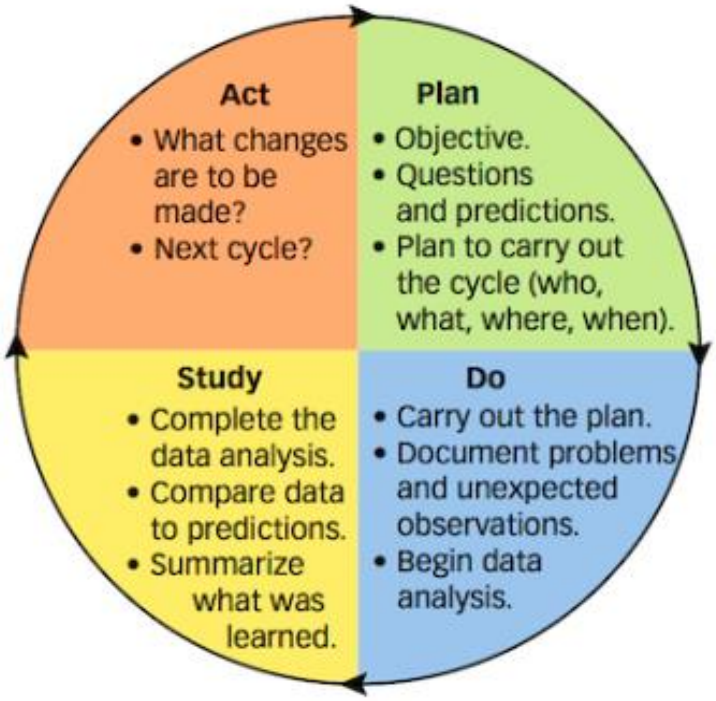
Robust findings from investigations and reviews provide key insights and learning opportunities, but they are not the end of the story.

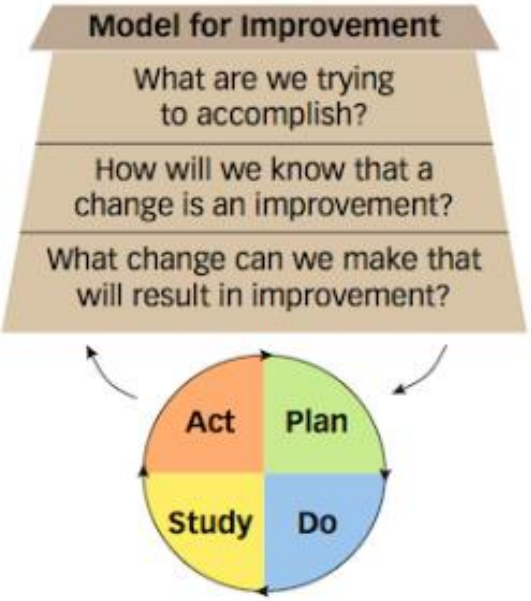
Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and investigations. Therefore, Safety recommendations will be agreed by the Executive led PSII sign off meeting and feed into the work plans for the Quality Improvement and Transformation teams.

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

Reports to the relevant board sub committees will include aggregated data on:

- patient safety incident reporting
- findings from patient safety incidents
- audit and review findings
- progress against the PSIRP
- results from monitoring of improvement and transformation plans
- from an implementation and an efficacy point of view
- results of any surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of any surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.





Roles and responsibility in the new system

Norfolk and Norwich University Hospitals NHS Foundation Trust is a complex system and has been building a comprehensive patient safety network. The governance structures at the Trust were considered in formulating this plan, and here is an outline of the core meetings and committees which represent our trust-wide approach, bringing the Trust together as a system which will support the implementation and progression of PSIRF.

The **Trust Board** seeks assurance that high quality services are being delivered through its sub-committees and presentation of data within the monthly Integrated Performance Report.

The **Quality and Safety Committee (Board Sub-Committee)** with a Non-Executive Director chair scrutinises quality information and that provided through sub-committees on the quality of care provided.

The **Clinical Safety and Effectiveness Sub Board** is chaired by an Executive Director, the Medical Director. This monthly meeting will have oversight of performance and governance arrangements in the Trust regarding patient safety, clinical standards and audit.

The **Hospital Management Team** oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Divisions and the Executive Team

Progress of PSII, ensuring required standards are met will be overseen by **PSII Review and Sign off Group**. Safety recommendations from PSII approved by this group will be assigned to the Quality Improvement Team or Transformation Team for action.

The **Patient Engagement and Experience Sub Board** chaired by an Executive Director, the Chief Nurse. This monthly meeting has oversight of performance and governance arrangements in the Trust regarding patient engagement and experience.

The **Risk Oversight Committee** chaired by an Executive Director; The Chief Nurse supports oversight of all risks within the Trust

The **Quality Programme Board** chaired by the Chief Executive Officer has oversight of all quality priority and improvement work.

The **Transformation Steering Group**, chaired by the Transformation Director, has oversight of the prioritisation and delivery of transformational change projects and programmes.

> The secret of change
> is to focus all of your energy
> not on fighting the old, but on
> building the new
>
> Socrates

With thanks to North Bristol NHS Trust.