# Central Surrey Health
# Patient Safety Incident Response Plan
# 2024/2025

CSH Surrey

NHS

# Contents

# 1 Introduction

This patient safety incident response plan (PSIRP) sets out how Central Surrey Health (CSH Surrey) intends to respond to patient safety incidents in the next 12-18 months after publication. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Proposed changes to the plan go through our internal ratification processes via the Quality and Clinical Governance Group and signed off by the CSH Board before approval by the ICB.

This PSIRP will transfer the focus from the quantity of our Patient Safety Incident Investigations (PSIIs) to the quality of them. It will also help us improve our PSIIs by putting the emphasis on a systems-based approach to investigations with the aim of preventing or measurably reducing repeat patient safety risks and incidents.

All providers or provider groups/networks delivering NHS-funded care are required to produce a PSIRP. The PSIRP should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

Our PSIRF plan can be reviewed in line with the current PSIRF Policy in the Blink (RM 08).

# 2 About CSH Surrey

CSH Surrey is a social enterprise (not-for-profit) community services provider, enthusiastic about helping people live the healthiest lives they can in their communities. We focus every day on making a difference for the people we care for (adults, children, and their families). Everything we do, we do with CARE as signposted in our core values.

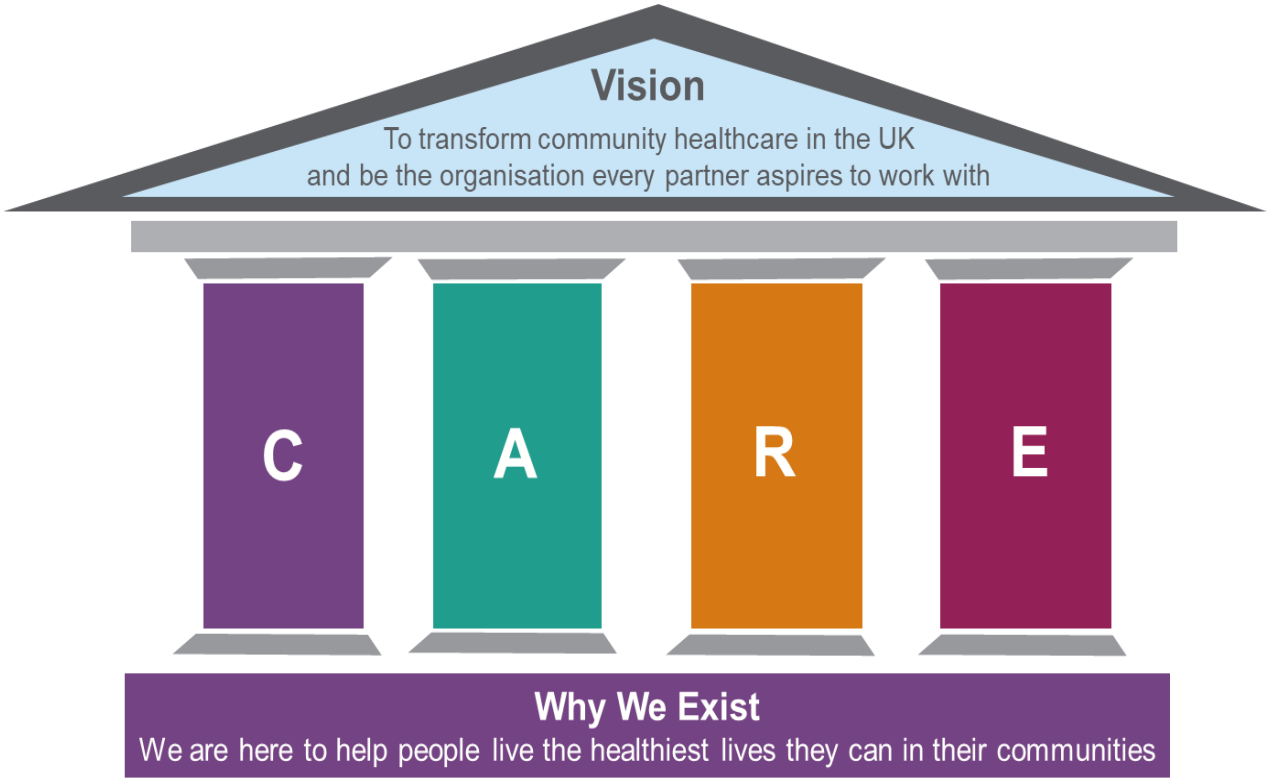
## 2.1 Core Values

**CARE**

**Because we care about our patients and clients, our colleagues, and our partners.**


| | |
|---|---|
| **C**ompassion | We look after each other, speak kindly, and work collaboratively. |
| **A**ccountability | We take responsibility, act with integrity, and speak with honesty. |
| **R**espect | We listen, value, trust, and empower people and treat them with dignity. |
| **E**xcellence | We are professional, aim high, value challenge, and never stop learning or innovation. |

**Fig. 1: Our Vision Statement and Value Acronym**




**How We Do It**

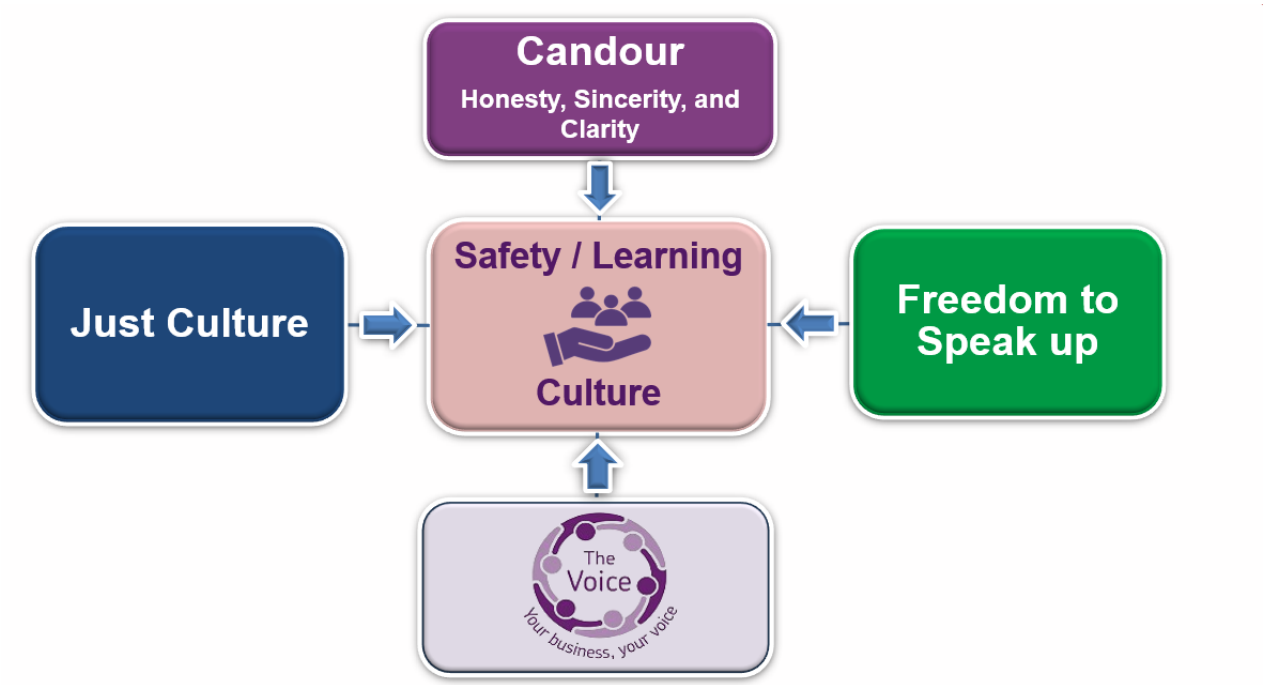
- We are an employee-owned, not-for-profit organization and have a passion for people and each other.
- We believe we can make a difference…every day.
- We focus on delivering the best we can for the people we care for… at every contact.
- We have a relentless commitment to excellence and learning, enabling us to deliver high quality and safe local healthcare to you.

## 2.2 Our Patient Safety Culture

CSH Surrey's strategic values champion a fair and just cultural approach for our staff, who also serve as co-owners. Our organisation is dedicated to fostering a culture where every individual feels not just heard, but truly valued and empowered. The voice of our co-owners resonates loudly through elected group representatives who regularly meet with the board and executives, the Voice, facilitating a direct channel for staff feedback and concern resolution.

These core values form the bedrock of psychological safety, fostering an environment of openness and transparency. This approach not only encourages but also celebrates incident reporting and the raising of concerns. At CSH Surrey, we believe in a workplace where everyone's input matters, creating a collaborative and supportive atmosphere for both staff and co-owners alike.

**Fig. 2: Our Patient Safety Culture**




Learning and insight gained from incidents, investigations, safety huddles, and from our learning events will play a crucial role in shaping and enhancing the safety culture within the organisation.

Key steps to continuously improve our safety culture are highlighted in section 7.

# 3 Our Services

CSH Surrey is one of the eleven health and social care providers who are known as the Surrey Heartlands Health and Care Partnership. We work together to improve care across the Surrey Downs, Northwest Surrey, Guildford, and Waverley areas.

CSH Surrey has provided community health services for adults, children and their families in their homes, schools, clinics, and community hospitals of mid-Surrey since 2006.

A large part of CSH Surrey's work is to provide community services for children throughout the county. The Children and Family Health Surrey (CFHS) partnership provides community health service for children and young people from birth up to 19 years of age and their parents and carers.

CFHS provides a single service under one contract in collaboration with other providers.

CSH Surrey is in partnership with other community services in the Northwest Surrey Alliance with the aim to achieve the total well-being of our community, shifting our focus from health provision responding to sickness to prevention in the fullest sense.

**Fig. 3: Key areas of operation**


## The following are the services we offer for adults and children:

| Children Services | Adult Services |
|---|---|
| • Children Continence<br>• Children's Community Nursing<br>• Community Health Early Support<br>• Continuing Health Care<br>• Dietetics<br>• Family Nurse Partnership<br>• Health Visiting<br>• Immunisations and Child Health<br>• Looked After Children<br>• Occupational Therapy<br>• Physiotherapy<br>• Safeguarding Children<br>• School Nursing<br>• Specialist School Nursing<br>• Speech and Language Therapy<br>• Tongue Tie Service | • Community Hospitals<br>• Community Nursing<br>• Community Rehabilitation<br>• Continence Service<br>• Diabetes Specialist Nursing<br>• Dietetics<br>• Frailty Hubs and Community Matron Service<br>• Heart Failure<br>• Hospital @ Home (Virtual Wards)<br>• Insulin Administration<br>• Outpatient Nursing<br>• Phlebotomy<br>• Podiatry<br>• Radiology<br>• Respiratory<br>• Safeguarding Adults<br>• Single Point of Access<br>• Speech and Language Therapy<br>• Tissue Viability<br>• Urgent Community Response<br>• Walk-In Centres |
| • Infection Prevention and Control (covers both Adult and Children Services)<br>• Medicines Management (covers both Adult and Children Services) | |

# 4 Defining Our Patient Safety Incident Profile

At CSH Surrey, we are committed to learning from patient safety incidents and using the significant experience of our staff, along with feedback from patients, families, and carers, to develop our understanding of all aspects of patient safety continuously. In preparing this PSIRP, we used multiple sources of information and data to identify the overarching and critical patient safety issues contributing to organisational risk.

We conducted a comprehensive review of systems and processes for managing and monitoring incidents across the organisation. The review was conducted between May 2023 to November 2023. Data reported in Datix between August 2020 and August 2023 was pulled to provide an analysis of incidents, serious incidents, and other data as highlighted above.

We analysed and presented this data to stakeholders and staff across the organisation as part of the sensitisation process to create awareness for PSIRF and as an opportunity for all staff to contribute to the decision about our local priorities.

### Our data sources include:

- **Incidents:** reported on our risk management system (Datix) and other sources, e.g., serious incidents reported to the Integrated Care Board (ICB), safeguarding incidents, and incidents reported to the local authority
- **Complaints:** formal and informal complaints in the Datix system
- **Patient Advice Laison Service (PALS) records:** reported under various titles in the Datix system
- **Coroner's inquest:** investigations held by the coroner following the deaths of patients. CSH Surrey is informed about deaths with a formal request from the coroner to participate in the investigation
- **Mortality review:** the medical examiner's system conducts these reviews to scrutinise the death of patients. CSH Surrey conducts an in-house mortality review to learn and improve from the findings. Information about the medical examiner's review of fatalities is reported in our risk management system
- **Safety huddles:** information gathered about the decision-making process following potential serious incidents
- **National and local audits:** findings from national and local audits were reviewed as one of the channels of improvement
- **Risk register:** this is the register of potential threats to the safety of patients and care

- **Staff feedback:** Feedback from staff in our focused group and engagement meetings, provided real-time feedback. Data from staff from staff survey results was also included.

- **Patient feedback:** Direct patient feedback, including information from the Friends and Family Tests via a data analysis from IWantGreatCare

- **Data from specialist areas:** safeguarding (e.g., Section 42s - please refer to Patient Safety Incident Response Policy (RM 08) for more information about section 42 enquiries), falls, medication management, estates, medical devices tissue viability, infection prevention and control, and information governance

# 5 Stakeholders Engagement

The safety incident profile, which has informed the PSIRF plan, was developed in collaboration with both external partners and internal stakeholders.

We engaged directly and indirectly with our external partners, including the Surrey Heartlands Integrated Care Board (ICB), regional and national patient safety groups, the Care Quality Commission (CQC), local coroners, Healthwatch Surrey, and members of our local networks, including acute trusts and other community services. Data was collected from these sources to inform our incident profile and engagement with our stakeholders.

All internal stakeholders from our gap analysis were part of the implementation team or became involved in the implementation from the early stages. The Quality and Clinical Governance Group (Q&CGG), comprising key internal stakeholders, became the core of the PSIRF implementation team.

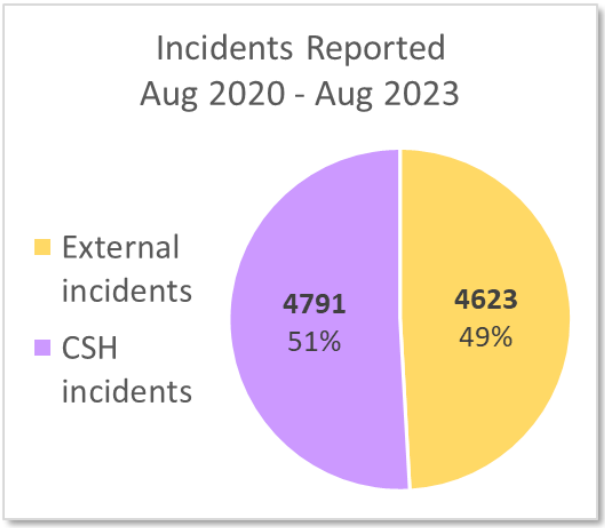
The Q&CGG includes representatives from all CSH Surrey clinical services (Adults and Children), human resources, the Communications Team, information technology, and other stakeholders. Initial stages and implementation process were agreed upon at the Q&CGG meeting, followed by monthly updates of PSIRF as a standing agenda.

In addition to engaging stakeholders in Q&CGG meetings, a stakeholder engagement, and PSIRF awareness drive was launched throughout the organisation, involving all clinical teams in adult and children's services. As part of our engagement strategy, we discussed the risks to patients relevant to each area.

We made presentations to the Board and Quality & Safety Committee, departmental teams, senior leadership groups, and specialist practitioners, including safeguarding, infection prevention and control (IPC), falls lead, lead pharmacist, tissue viability, information governance specialists, information technology, children services to understand the risks better and need for improvement in specialist areas.

# 6 Data Analysis

**Fig. 4: Reported Incidents**

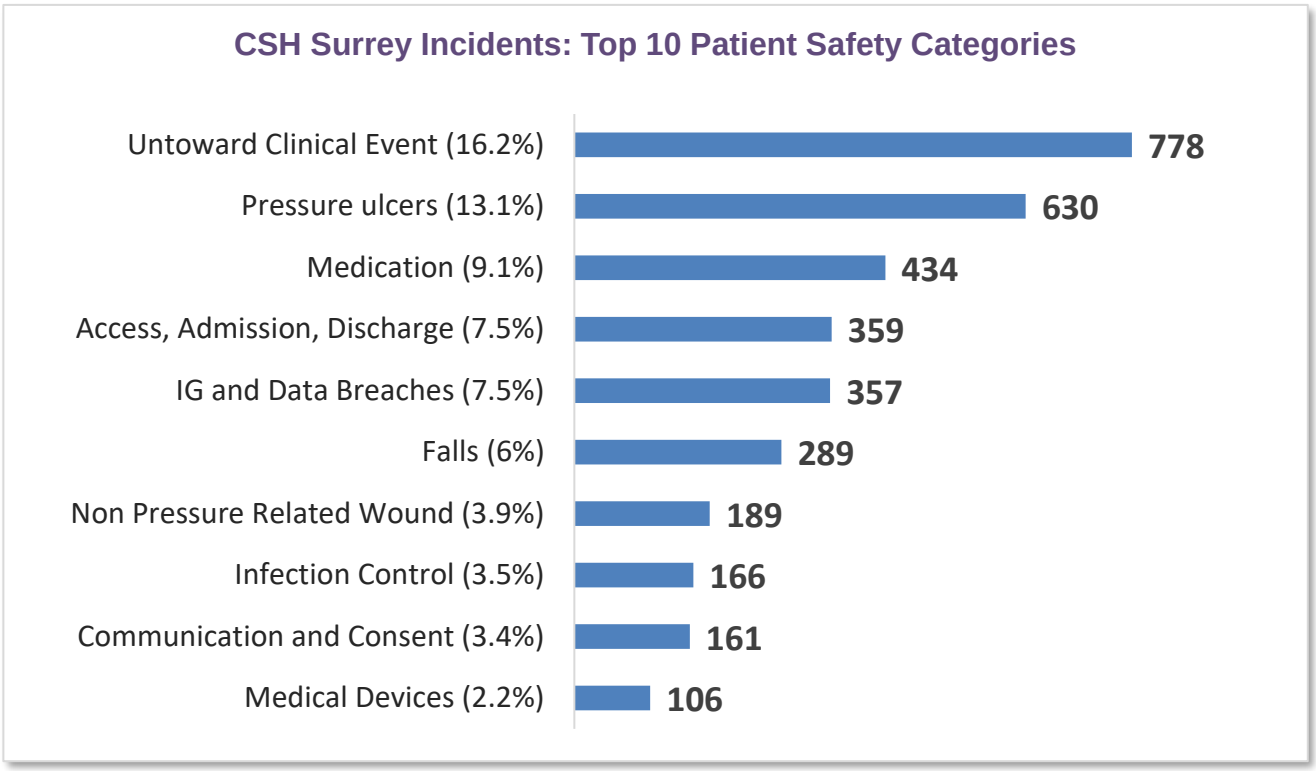



In the three years from August 2020 to August 2023, CSH Surrey reported 9,414 incidents.

Out of the reported incidents, 49% (4,623) were categorised as external incidents: not attributed to the care provided by CSH Surrey.

The remaining 51% (4,791) were attributed to care provided by CSH Surrey.

**Fig. 5: The top 10 categories of patient safety incidents**



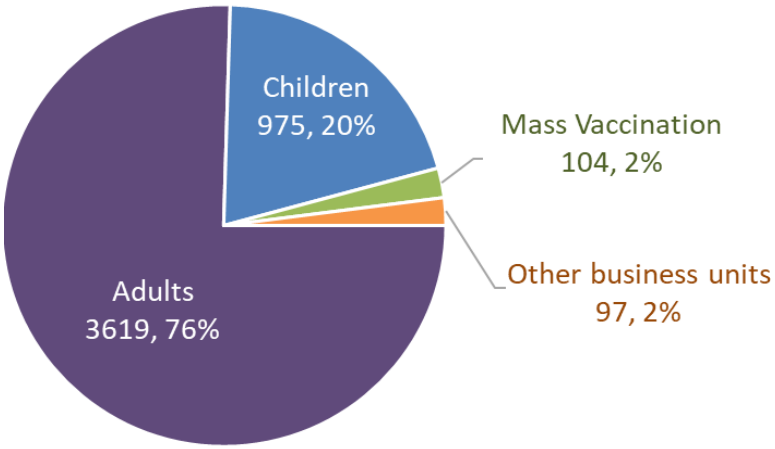

The categories of incidents highlighted above accounted for 72.4% of internal incidents reported by CSH Surrey.

Patient deterioration accounted for 76.5% of untoward clinical events, whilst medical device related incidents accounted for 10%. Delay or failure to diagnose accounted for 1.7%. Other categories included delay or lack of clinical risk assessment, delay, or difficulty in obtaining clinical assistance, complications, and treatment given to the wrong person.

The top medications involved in medication error incidents were:

- Insulin, accounting for 23.7% (103 episodes)
- Human papillomavirus vaccine (HPV), accounting for 4.8% (21 episodes)
- Morphine, accounting for 4.8% (21 episodes)
- Vitamin B12 (hydroxocobalamin), accounting for 4.3% (19 episodes)
- Influenza vaccine, accounting for 3.9% (17 episodes)

**Fig. 6 Incidents by Business Unit**




Patient safety incidents that were attributed to CSH Surrey were reported in three business units of the organisation: Adult Services, Children Services, and Mass Vaccination.

The other business units (including Human Resources, Finance, and Digital) reported the remaining incidents. These did not usually involve incidents linked to patients.

Care provided by other community services like care homes, hospices, schools, and in patients' homes were the sources of external incidents. 54% of those incidents were pressure ulcers or skin ailments identified and reported on admission to our services. Access admission and discharge accounted for 8.8% (333) incidents; these incidents primarily related to transfer between our service and the acute settings and vice versa.

### Serious incidents (SIs)

Serious incidents are events in health care where the learning potential is so great or the consequences to patients, families, carers, staff, or organisations are so significant that they warrant using additional resources to mount a comprehensive response. Under the previous SI framework, serious incidents were reported externally to the ICB and NHS England nationally and required thorough investigation. CSH Surrey reported eleven SIs during the period from August 2022 to August 2023.

### SIs Reported by Business Units

- Adults' services reported eight SIs
- Mass Vaccination reported three SIs, all inoculation incidents, which were automatically reported as SI regardless of level of harm

**Table 1: List of serious incidents reported**

| **Untoward clinical events (3)** |
|---|
| Typically included delays in treatment and diagnosis, failures, and poor monitoring and management of patients that result in harm. These accounted for the three incidents. |
| **Medication error incidents (2)** |
| Two SIs were reported as medication error incidents. The medication involved in both incidents was insulin. In addition to serious incident investigation, these incidents triggered safeguarding (Section 42) and were investigated externally. |
| **Inoculation injuries and sharps (3)** |
| Three incidents were reported in this category, all from the mass vaccination campaign. |
| **Allegation of abuse (2)** |
| Two incidents were reported as allegations of abuse by staff on patients/service users (one adult and one child affected). The allegation of abuse of a child was unsubstantiated. The adult incident was an allegation of sexual abuse against an agency staff who no longer work for CSH Surrey, but appropriate actions have been taken. |
| **Infection prevention and control (1)** |
| COVID infections |

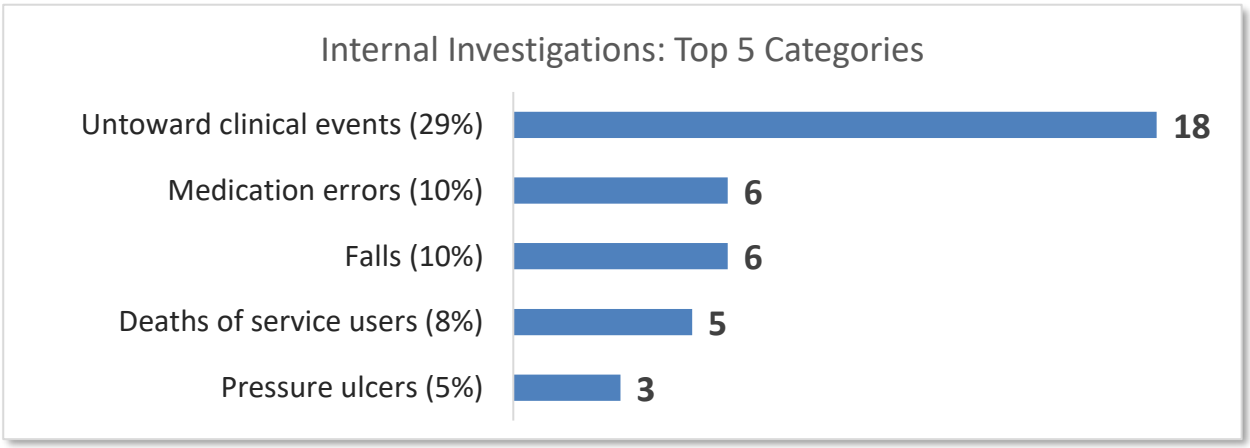
### Internal Investigations (RCAs / Patient Safety Investigations)

In the period August 2020-August 2023, 62 incidents that did not meet the criteria of serious incidents were investigated internally. These incidents attracted detailed formal investigation using root cause analysis (RCA) but were not reported to external bodies. They were monitored internally via our incident management process.

We used other methodologies like Situation, Background, Assessment, and Recommendation (SBAR) to investigate and report a small proportion of internal incidents.

In total, 80.6% (50) incidents were within the Adult Business Unit, and 11.3% (7) were reported under Children Services. The main categories of internal investigations are highlighted in Fig. 7.

**Fig. 7: Internal investigations**



### Other sources of risk

### Formal complaints

In the period under review, 147 formal complaints were received. Complaints that had significant patient safety concerns were reported as incidents and investigated.
The complaints process was one of the routes of identification of incidents (37).

**Table 2: The top five categories of formal complaints**

| Top 5 Complaints Subjects | Children Services | Adult Services | Total |
|---|---|---|---|
| Access, Admission, Transfer, Discharge | 21 | 56 | 77 |
| Communication and Consent | 8 | 14 | 22 |
| Staff Attitude and Behaviour | 3 | 17 | 20 |
| Untoward Clinical Event | 0 | 19 | 19 |
| Medicines | 0 | 4 | 4 |

These themes are like those of incidents and serious incidents.

### Patient Advice and Liaison Service (PALS)

Within the three-year period, CSH Surrey had 717 PALS cases. The top types were:

- Informal Concern (399)
- Signposting (48)
- Advice/information (40)

### Safeguarding concerns with Section 42

There were 180 safeguarding reports with Section 42 reports.

The top categories were:

- Medication incidents (54)
- Missed visits and delays/failure in access to care (29)
- Pressure ulcers (20)

### Inoculation injuries/sharps

These were reported by the Mass Vaccination Team during COVID, but this team is no longer part of CSH Surrey.

**Table 3: Summary of incidents in our patient safety profile**

| Key patient safety profile | All Incidents | Serious Incidents | Internal Investigations | Formal Complaints | PALS | Adult Section 42s | Coroners Investigations | Mortality reviews | Safety Huddles |
|---|---|---|---|---|---|---|---|---|---|
| Untoward Clinical Event | 779 | 3 | 18 | 16 | - | 8 | - | - | - |
| Pressure Ulcers – After admission | 630 | - | 3 | - | - | 18 | - | - | - |
| Medicines | 434 | 2 | 6 | | - | 54 | - | - | - |
| Access, Admission, Discharge | 359 | - | 3 | 60 | - | 57 | - | - | - |
| Information Governance | 357 | - | 3 | - | - | | - | - | - |
| Falls - patient | 289 | - | 4 | - | - | 10 | - | - | - |
| Staffing | 241 | | - | - | - | | - | - | - |
| Violence / Abuse of Staff | 206 | 2 | 4 | - | - | 10 | - | - | - |
| Security and Property | 171 | - | - | - | - | - | - | - | - |
| Infection Control | 165 | 1 | 2 | - | - | - | - | - | - |
| Communication and Consent | 161 | - | 1 | 18 | - | 4 | - | - | - |
| Total – Other | 999 | 3 | 14 | - | - | 11 | - | - | - |
| **Three-year total** | **4791** | **11** | **62** | **145** | **45** | **180** | **38** | **96** | **53** |
| **Annual Average** | 1642 | **3.6** | 21 | 48 | 15 | 60 | 12 | 32 | 17 |

# 7 Defining Our Patient Safety Improvement Profile

Patient safety events provide insights into learning opportunities where the potential for improvement activity is the intended outcome. At CSH Surrey, we will translate improvement into meaningful, sustainable, and effective action to reduce the risks to patients and those receiving and delivering care. This will be achieved by focusing on a culture of learning and upholding the principles of a just and open culture where learning will always be prioritised.

CSH Surrey's strategy for learning and improvement will include:

- **Robust patient safety training**

  We will implement robust patient safety and incident investigation training, starting with our board and senior leadership, and to all our staff to understand safety science and the principles of a just and open culture.

- **Quality improvement (QI) capacity**

  We will develop our quality improvement capacity through quality improvement education and capacity building throughout the organisation. This will be accomplished by linking with our network partners for QI training to key members of various QI workstreams. QI methodology will be applied to our learning process to ensure that baseline and outcome measures are clearly defined to monitor (and determine) if the changes had the intended effect.

- **Patient safety quality improvement workstreams**

  In partnership with the quality improvement and operational teams, we will develop improvement workstreams around each of our core local patient safety priorities, which has been agreed through consultation with staff groups throughout the organisation.

  These include:

  - Problems in treatment (delays, diagnosis, inappropriate)
  - Medication error reduction in insulin administration
  - Reduction in medication errors for children
  - Reduction of falls (in-patient and during the provision of service in the community)
  - Reduction of pressure ulcers for patients in our care
  - Reductions in avoidable harm and distress to families of patients in end-of-life care
  - Reduction in unnecessary breaches of patient information (as per our information governance protocols)

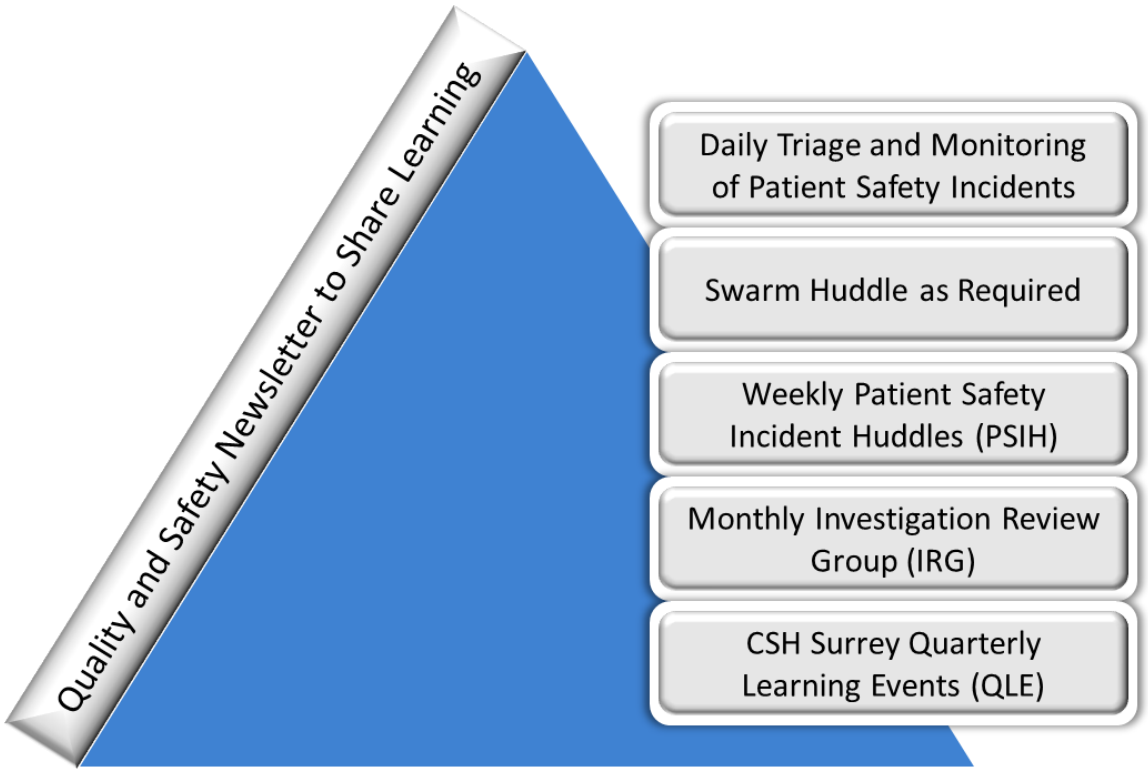
Our improvement plan has been developed to be closely aligned with our Quality Strategy to support the strategic objectives and the improvement goals of PSIRF. We have consulted key stakeholders including our senior leadership teams.

Our improvement plan will complement ongoing improvement projects in the organisation, by providing real-time data from patient safety events to feed into improvement activities.

Ongoing improvement workstreams identified include:

- Effectiveness of teleconsultations and their impact on patients receiving speech and language therapy (SLT)
- Catheter care pathway
- Community Nursing Improvement Group
- Reducing inappropriate catheter management
- Increasing patient experience feedback in the Community Rehabilitation Team
- Community Hospitals Deteriorating Patient Review Group

**Fig. 8: CSH Surrey learning and improvement pyramid**




### Daily Triage and Monitoring of Patient Safety Incidents

All incidents reported on Datix will be triaged by the Patient Safety Team. Incidents from other sources, like complaints, are reviewed by the Patient Experience Team and advised as incidents if considered patient safety incidents. All incidents identified for discussion are escalated to the weekly Patient Safety Incident Huddles.

### Swarm Huddle

To evaluate the potential of further risks to patients and to extract immediate learning from incidents, all incidents will be subjected to a swarm huddle within 12 hours of the identification of incidents. The nature and type of the huddle and the participants in a swarm huddle depend on the nature of the incident. Please refer to the CSH Surrey Patient Safety Plan which can be found on the blink and in the CSH patient safety policy.

### Weekly Patient Safety Incident Huddles (PSIH)

Incidents reported are triaged and reviewed by the Patient Safety Team to identify and group incidents according to our patient safety priorities. At a PSIH, we confirm the level of harm of patient safety incidents, evaluate the support required for staff and patients (Duty of Candour), agree on immediate actions, agree on the appropriate incident response plan, the lead, and who should be involved in the response. The support required for staff and patients will be assessed by line managers and senior team members following the completion of recommended training as described in our PSIRF Policy.

### Investigation Review Group (IRG)

This monthly meeting is where all incidents CSH Surrey investigates are signed off.
It is chaired by either the Medical Director or the Director of Quality and Chief Nurse.
Reports of learning from incident investigations are discussed and approved at the meeting and referred to the quality improvement agenda. Actions will be reviewed and agreed upon with the test of the effectiveness of all actions agreed from the investigation.

### Quarterly Learning Events

At the Quarterly Learning Event, CSH Surrey explores the opportunity to gain experience and show care for improving their patient safety events. Topical issues from our improvement plan will be discussed to share learning from patient safety incidents for the whole organisation. External partners will be invited to participate in our Quarterly Learning Events.

Our Quarterly Learning Events allow the sharing of learning from incidents across the whole organisation which encourages cross-organisational learning. Further, our Datix system is fully transitioned to the Learn from Patient Safety Event (LFPSE) system which facilitates multi-system reporting and learning. CSH Surrey encourages multi-organisational investigation of patient safety events.

### Multi-Organisation and Cross-System Incidents and Learning

We actively collaborate with local and national partners at all levels through various engagement avenues. Our interaction with the ICB occurs at our weekly (when available), and monthly, Investigation Review Group meetings, at our Quarterly Learning Events, and during local Clinical Quality and Improvement Meetings.

Additionally, we participate in, and contribute to, our Local Patient Safety Specialist Network meetings, fostering an environment for learning and shared insights.

There are however some challenges of multi-organisational work which include privacy concerns (the problem of establishing secure data-sharing protocols and agreements) and resource constraints. These can be overcome by pooling resources and expertise together to maximise impact and effectiveness.

National incident reporting is a fundamental aspect, aligning with our commitment to national priorities as highlighted in section 8.

We engage in inter-organisational liaison to address cross-system incidents and ensure statutory notifications and reporting to regulatory bodies as required.

Within the learning and improvement pyramid (Fig. 8), numerous opportunities arise to identify and disseminate valuable information that supports safety improvement. This information, gleaned at the team, department, organisation, or system level, allows us to pinpoint commonly reported incident types.

By triangulating this data with information from diverse sources such as complaints, claims, and coroner inquests, we gain a comprehensive understanding of the nature of incidents, assess associated risks, and unearth opportunities for improvement.

Furthermore, we actively involve patients, relatives, carers, and patient safety partners throughout this process, recognising their invaluable perspectives in shaping a safer healthcare environment.

### Celebrating Success

At CSH Surrey, we celebrate success from positive outcomes. Staff are encouraged to report on our Datix system, and in the Blink, instances reflecting good care (‘Greatix’) to support cross-system learning.

Our quarterly learning events also provide an opportunity to showcase positive outcomes and share success. CSH Surrey Quality and Safety Newsletter will highlight our Greatix of the month throughout the organisation.

# 8 Our Patient Safety Incident Response Plan: National Requirements

Please refer to the Patient Safety Incident Response Policy Policy in the Blink for details of acronyms in the response plan below.

**Table 4: National requirements for patient safety incident response plan**

| | Patient Safety Incident Type | Required Response | Anticipated Improvement Route |
|---|---|---|---|
| NATIONAL PRIORITIES | • Incidents meeting the Never Event Criteria | • Swarm Huddle within 12hours of identification.<br>• PSII | • Quarterly Learning Event<br>• Quality and Safety Newsletter |
| | • Death thought more likely than not due to problems in care, meeting the Learning from Deaths Criteria, including Deaths of Patients detained under the Mental Capacity Act (1983) or where Mental Capacity Act (2005) applies. | • Mortality case record reviews<br>• SJR via medical examiner<br>• PSII<br>• Participation in inquests and learning from Inquests | • QI workstream<br>• Quarterly Learning Event<br>• Quality and Safety Newsletter |
| | • Maternity and neonatal incidents meeting The Maternity and Newborn Safety Investigations (MNSI Criteria) including maternal deaths and incidents meeting 'Each Baby Counts' Criteria. | • Refer to Maternity and Newborn Safety Investigation<br>• AAR for immediate learning | • Sharing Learning at Q&CGG meeting<br>• Quality and Safety Newsletter<br>• Improvement actions from MNSI |
| | • Death of a person with learning disabilities or an autistic person. | • Learning Disabilities Mortality Review (LeDeR) | • Quarterly Learning Event |
| | **Safeguarding incidents meeting criteria**<br>• Children, or young people, on a child protection plan; looked after children plan or a victim of wilful neglect or domestic abuse/violence<br>• Safeguarding incidents for adults (over 18 years old) who receive care and support needs from their local authority | • CSH Surrey named adult safeguarding advisors to lead on completing Section 42s<br>• The attention of local authority contribution towards statutory investigations, domestic, and independent inquiries<br>• Joint targeted area inspections, child safeguarding<br>• Special educational needs and disability (SEND) inspections<br>• Contributing to scoping exercises and safeguarding practice reviews | • Sharing learning at Q&CGG<br>• Quarterly Learning Event<br>• Quality and Safety Newsletter |
| | • Child death | • Initiate the child death review process | • Quality and Safety Newsletter<br>• Improvement actions from the child death process |
| | • Healthcare-acquired infections (HCAI) and issues with infection control procedures | • AAR<br>• HCAI and outbreak reviews | • QI workstreams<br>• Quarterly Learning Event<br>• Quality and Safety Newsletter |
| | • Incidents in screening programmes | • Reported to NHS England as per the Guidance on incidents in NHS screening<br>• AAR for local learning | • Recommendations transfer to QI workstream |

# 9 Our Patient Safety Incident Response Plan: Local Focus

We will use NHS PSIRF recommended methodologies, including MDT team reviews, swarm huddles, After Action Reviews, thematic reviews, and Patient Safety Incident Investigations (PSII), to conduct our response to patient safety events. The decision for a PSII or other investigations is taken at the weekly Incident Review Group meeting.

**Table 5: Local focus of patient safety response plan**

| | Patient Safety Incident type | Required Response | Anticipated Improvement Route |
|---|---|---|---|
| LOCAL – CSH SURREY | • Problems in treatment including:<br>- Treatment Delay<br>- Delay in diagnosis<br>- Failure to recognise deterioration<br>- Wrong and inappropriate treatment | • Swarm Huddle as soon as identified.<br>• PSII<br>• AAR<br>• Harm review | • QI workstream<br>• Quarterly audits as built into the audit schedule for the organisation.<br>• Quality and Safety Newsletter<br>• Quarterly Learning Events |
| | • Pressure ulcers (PU) acquired during care provision by CSH Surrey | • PSII<br>• AAR<br>• Thematic Reviews | • PU quality improvement work at Quarterly Learning Events |
| | • Falls in our in-patient unit | • AAR<br>• Thematic reviews | • Falls quality improvement work<br>• Quarterly Learning Events |
| | • Medication incidents (maladministration, delays, wrong and medications incidents involving insulin administration) | • AAR<br>• PSII<br>• Thematic reviews | • QI workstream<br>• Quarterly Learning Events<br>• Quality and Safety Newsletter |
| | • Medication incidents involving children | • AAR<br>• PSII | • QI workstream for children's medication<br>• Quality and Safety Newsletter |

| | | | |
|---|---|---|---|
| LOCAL – CSH SURREY | • Violence and aggression - incidents of violence and aggression lead to distress and avoidable harm for patients and staff | • Supportive debriefing<br>• Zero tolerance warning letters | • Thematic reviews and learning events<br>• Training<br>• The Voice |
| | • Incidents due to problems in admission, discharge, and patient transfer leading to avoidable harm | • Monthly locality admission and discharge learning events | • Feedback – leading to improvement work.<br>• Share learning at network meetings |
| | • Inappropriate and unnecessary use of patient and staff information leading to information breaches | • AAR<br>• Information governance training<br>• ICO reportable Incidents | • Quality and Safety Newsletter<br>• Information governance sessions<br>• Quarterly Learning Event |
| | • Incidents leading to distress in the management of end-of-life care for patients and families | • AAR<br>• Working with families | • Audit of the management of end-of-life care<br>• Improvement work for end-of-life care<br>• Quality and Safety Newsletter |
| | • Incidents resulting in moderate or severe harm | • Swarm huddle within three days of identification<br>• Statutory Duty of Candour<br>• Agreed methods if not part of our local focus | • Thematic analysis of ongoing patient safety risks |
| | • No/low harm incidents | • AAR<br>• Case notes review<br>• Clinical audits<br>• Thematic analysis | |

### Indications for undertaking Patient Safety Incident Investigation (PSII):

PSII will be conducted in response to:

1. All 'Never Events'
2. Death of a patient, more likely than not, resulting from inappropriate care, including deaths awaiting a coroner's inquest where concerns and failings have been highlighted
3. Problems in treatment (including delays, inappropriate care, and failure to recognise deterioration), pressure ulcers, and medication incidents involving children and adults where significant failings have been identified from initial review and weekly Patient Safety Incident Huddle

CSH Surrey will undertake up to five to ten PSIIs in a calendar year which will be triggered in our weekly Patient Safety Incident Huddle.

### Local Response to National Priorities including Safeguarding

Response to some of the National priorities is led by relevant organisations like adult social care (Section 42 inquiries), child death reviews, etc**.** CSH will review these incidents for immediate learning and implement actions to prevent recurrence in the QI work streams.

Additional actions from the relevant body post investigation will be discussed at either the Quarterly Learning Event or the Quality and Clinical Governance Group meetings.

## 10 Consultation Record

| Individual's Name & Job Title or Name of Forum / Group | Date feedback received/minuted |
|---|---|
| Quality & Clinical Governance Group | August 2023 - February 2024 |
| Investigation Review Group | August 2023 - February 2024 |
| Adults Senior Management Group | August 2023 - February 2024 |
| Children Senior Management Group | August 2023 - February 2024 |
| Walk-in Centre Senior Management Group | August 2023 - February 2024 |
| Inpatient Team | August 2023 - February 2024 |
| Outpatient Services | August 2023 - February 2024 |
| Community Nursing Group | August 2023 - February 2024 |

# Equality Impact Assessment Tool

Equality statement

This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners**.** The intention is, as required by the Equality Act 2010, to identify, remove, or minimise discriminatory practice, with respect to, but not limited to, the nine named protected characteristics of age, disability, gender reassignment, marriage / civil partnership, pregnancy/maternity, race, religion/belief, sex and sexual orientation. It is also intended to use the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document is available in different languages and formats upon request to the Communications Team or the Equality and Diversity Lead.

| Assessment Item | Yes / No / N/A | Comments |
|---|---|---|
| Does the document affect one group less or more favourably than another on the basis of: | No | |
| • Age | No | |
| • Disability* | No | |
| • Gender reassignment | No | |
| • Marriage / civil partnership | No | |
| • Pregnancy/maternity | No | |
| • Race/nationality/ethnic origins (including gypsies and travellers) | No | |
| • Religion/belief | No | |
| • Sex | No | |
| • Sexual orientation | No | |
| • Other demographic groups that could be affected by this document? Socio-economic group, health inequality | No | |
| • Colleagues | No | |
| • Patients and families | No | |
| • Volunteer | No | |
| • Partners | No | |
| Is there any evidence that some groups are affected differently? | No | |
| If you have identified potential discrimination, are there any exceptions valid, legal, and / or justifiable? | N/A | |
| Is the impact of the document/guidance likely to be negative? | No | |
| If so, can the impact be avoided? | N/A | |
| What alternative is there to achieving the document/guidance without the impact? | N/A | |
| Can we reduce the impact by taking different action? | N/A | |

* Equality Act 2010 disability definition: physical or mental impairment which has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities.