Central Surrey Health
Patient Safety Incident Response Policy

CSH Surrey

NHS

Contents

1 INTRODUCTION

1.1 Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF). It sets out CSH Surrey's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues to learn and improve patient safety.

PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident response into a broader improvement system and prompts a significant cultural shift towards systematic patient safety management.

It supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF and which we can also align with existing organisational values:

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

1.2 Scope

This policy is specific to patient safety incident responses conducted solely for learning and improvement across all services provided by CSH Surrey. Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system; that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error,’ are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose.
The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

1.3 Definitions

Term / Acronym / Abbreviation	Definition / Explanation
AAR	**After Action Review:** a structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event an understanding of why the outcome differed from expected and the learning to assist improvement. AAR generates insight from the various perspectives of the team and can be used to discuss both positive outcomes as well as the incidents. It is based around four questions: • What was the expected outcome/ what was expected to happen? • What was the actual outcome/what happened? • What was the difference between the expected outcome and the event? • What is the learning?
HSSIB	**Health Services Safety Investigation Body:** an independent arm's length body of the Department of Health and Social Care who investigate patient safety concerns across the NHS in England and in independent healthcare settings where safety learning could also help to improve NHS care.
LFPSE	**Learn from Patient Safety Events Service:** a national NHS system for the recording and analysis of patient safety events that occur in healthcare.
PSIRF	**Patient Safety Incident Response Framework** replaces the serious incident framework as a patient safety incident response methodology.
PSPs	**Patient Safety Partners**: patient representatives employed by CSH Surrey and other care organisations to represent the voice of patients in organisations.
PSS	**Patient Safety Specialist**: patient safety specialists will be the lead patient safety experts in healthcare organisations, working full-time on patient safety. They will support the development of a patient safety culture and safety systems and have sufficient seniority to engage directly with the Executive Team.
Section 42	**The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. 'Safeguarding adults' is the name given to the multi-agency response used to protect adults with care and support needs from abuse and neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened. The findings from the enquiry are used to decide whether abuse has taken place and whether the adult at risk needs a protection plan. A protection plan is a list of arrangements that are required to keep the person safe.

Term / Acronym / Abbreviation	Definition / Explanation
SEIPS	**Systems Engineering Initiative for Patient Safety**: investigation methods to learn from patient safety events.
Swarm Huddle	A meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened, how it happened, and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

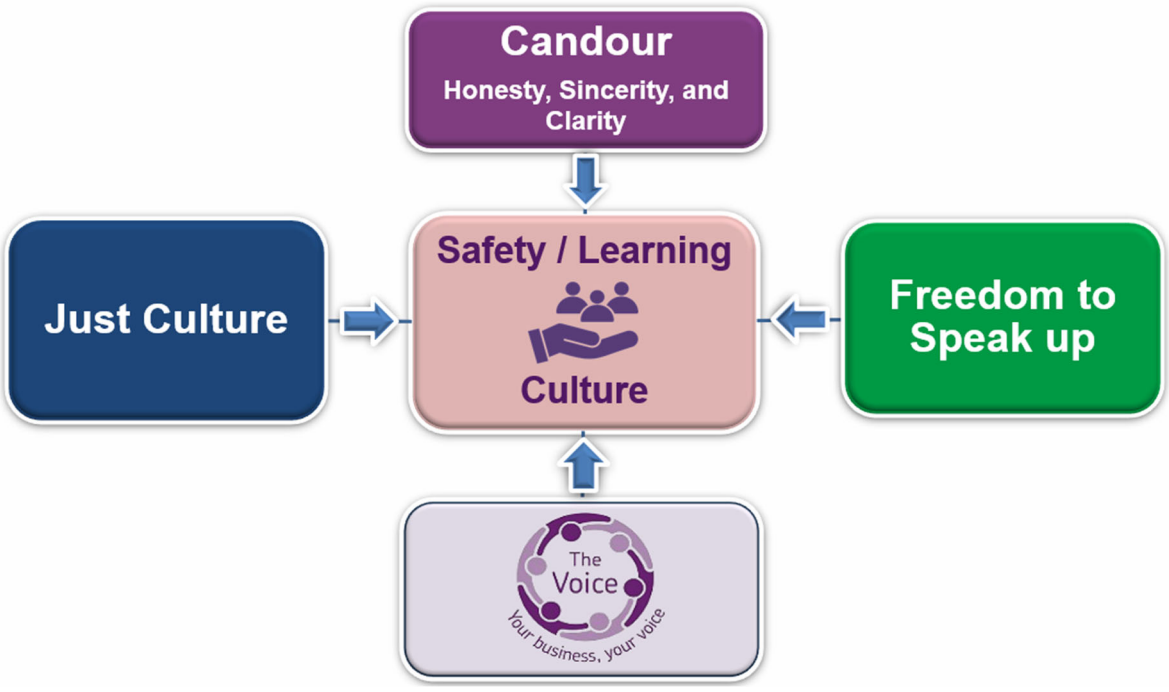
2 CSH SURREY PATIENT SAFETY CULTURE

CSH Surrey's strategic values champion a fair and just cultural approach for our colleagues, who also serve as co-owners of the business. 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 representatives, the Voice, who regularly meet with the board and executives, facilitating a direct channel for staff feedback and concern resolution.

These core values underpin the foundation of psychological safety, cultivating an environment characterised by openness and transparency. This approach not only promotes but also celebrates incident reporting and the expression of concerns. At CSH Surrey, we champion a workplace ethos where every individual's input holds significance, fostering a collaborative and supportive atmosphere for both staff and co-owners alike.

Fig. 1: Our patient safety culture



The principles of the NHS just culture guide have been implemented throughout the organisation to ensure the fair, open, and transparent treatment of staff involved in patient safety incidents. This principle has now become an integral part of our disciplinary policy and is a fundamental aspect of the procedures governing the review of incidents.

CSH Surrey conducts patient safety incident responses with the aim of learning and identifying system improvements to mitigate risks, prioritising these over considerations of accountability, liability, avoidability, and cause of death.

We have placed a strong emphasis on reinforcing the principles of just culture at the outset of all safety or governance-related meetings, as well as during any incident investigation meetings, like an AAR. A slide is shared to underscore our commitment to a just culture and to remind our staff of their obligation to uphold the principles of civility in their pursuit of a just culture.

This information has been communicated to all staff and will be reiterated both verbally and in writing to anyone interviewed for employment or as part of a learning response.

CSH Surrey's safety culture underwent a comprehensive review as part of the PSIRF implementation process. Although the organisation's values and systems already contribute to a robust safety culture, the implementation of PSIRF is expected to enhance it even further. Our gap analysis for PSIRF revealed discrepancies in the awareness levels among staff and certain managers regarding the concept of just culture and its essential components.

3 OUR PATIENT SAFETY PARTNERS (PSPs)

The PSP is a new and evolving role developed by NHS England and NHS Improvement, aimed at improving patient safety across the NHS. The main purpose of the role is to be a voice for the people who use NHS services and ensure that patient safety is at the forefront of all that we do.

PSPs can act as ‘knowledge brokers’ as they may often have insight as users of services across different parts of the NHS, or may have experienced avoidable harm, and can, therefore, help inform learning and holistic safety solutions that cross organisational boundaries.

They provide a different perspective on patient safety; one that is not influenced by organisational bias or historical systems. By reinforcing the patient voice at all levels in an organisation and across integrated care systems, PSPs can support a patient-centred approach to safer healthcare.

Our patient safety partners help us project patients' voices within our organisation. We will recruit patient safety partners who represent and believe in the value of diversity in our local population in Surrey.

The recruitment of PSPs strengthened the implementation of the National Patient Safety Strategy hinged on compassionate involvement, insight, and improvement.

Our PSPs are vital to the process of actively designing safer healthcare at all organisational levels. Patient safety partners play active roles in governance, for example, sitting on relevant committees to support compliance and monitoring of safety issues, providing appropriate challenges to ensure learning and service improvement, and in the development and implementation of relevant strategy and policy.

The role of a PSP is important in supporting the voices of patients and service users to be heard at all levels of the organisation and includes:

- Membership of quality and safety groups whose responsibilities include the review and analysis of safety data
- Networking with ICS and National PSPs
- Engagement with the Community of Practice and ICS-led PSP projects
- Involvement in patient safety improvement projects
- Working with teams and services to consider how to improve safety
- Involvement in relevant patient safety training
- Participation in investigation oversight groups where appropriate
- Participation in projects that focus on learning and involvement

CSH Surrey has appointed two Patient Safety Partners to reflect the diversity of our patients in Surrey.

4 ADDRESSING HEALTH INEQUALITIES

CSH Surrey is crucial in tackling health inequalities in alliance with our local partners, agencies, and services. We acknowledge that most of the fundamental factors driving inequalities in health are beyond the provision of healthcare. To address other factors of inequalities, CSH Surrey is part of the Northwest Surrey Alliance.

The alliance is formed of eleven organisations that include the acute sector, other community health providers, the local authority and borough councils, and local voluntary sector organisations, facilitating statutory services from birth to end-of-life care and enhancing the provision of community lifestyle, environment, and education.

Working with our local partners, CSH Surrey is committed to improving a person's support network and broadening relationships with housing, education, business, and other sectors to take a holistic view of improving outcomes. Vital to the alliance's success is harnessing local communities' skills, expertise, assets, and goodwill to develop a culture of healthy living and a supportive neighbourhood.

To further address health inequalities in our PSIRF plan, CSH Surrey will apply a flexible approach to the intelligent use of data. We will review our systems in annual audits to ensure

that groups or individuals, especially those with protected characteristics, are not disproportionately affected by poor outcomes.
CSH Surrey will use such information to ensure that responses to patient safety events and improvements address inequalities.

In our response to patient safety events, we will involve patients' families and staff to consider individual needs in identifying improvement.

We recognise the significance of data provided by Healthwatch (the organisation provides information and advice to help people access the services they need) in pinpointing marginalised sections of our patient community. By actively participating in alliances and harnessing insights from the Healthwatch data, we are committed to enhancing access to healthcare services for all members of our local population.

This strategic approach allows us to tailor our services, advocate for equitable care, and work collaboratively towards fostering a healthier and more inclusive community to deliver safe care for all.

5 ENGAGING AND INVOLVING PATIENTS, FAMILIES, AND STAFF FOLLOWING A PATIENT SAFETY INCIDENT

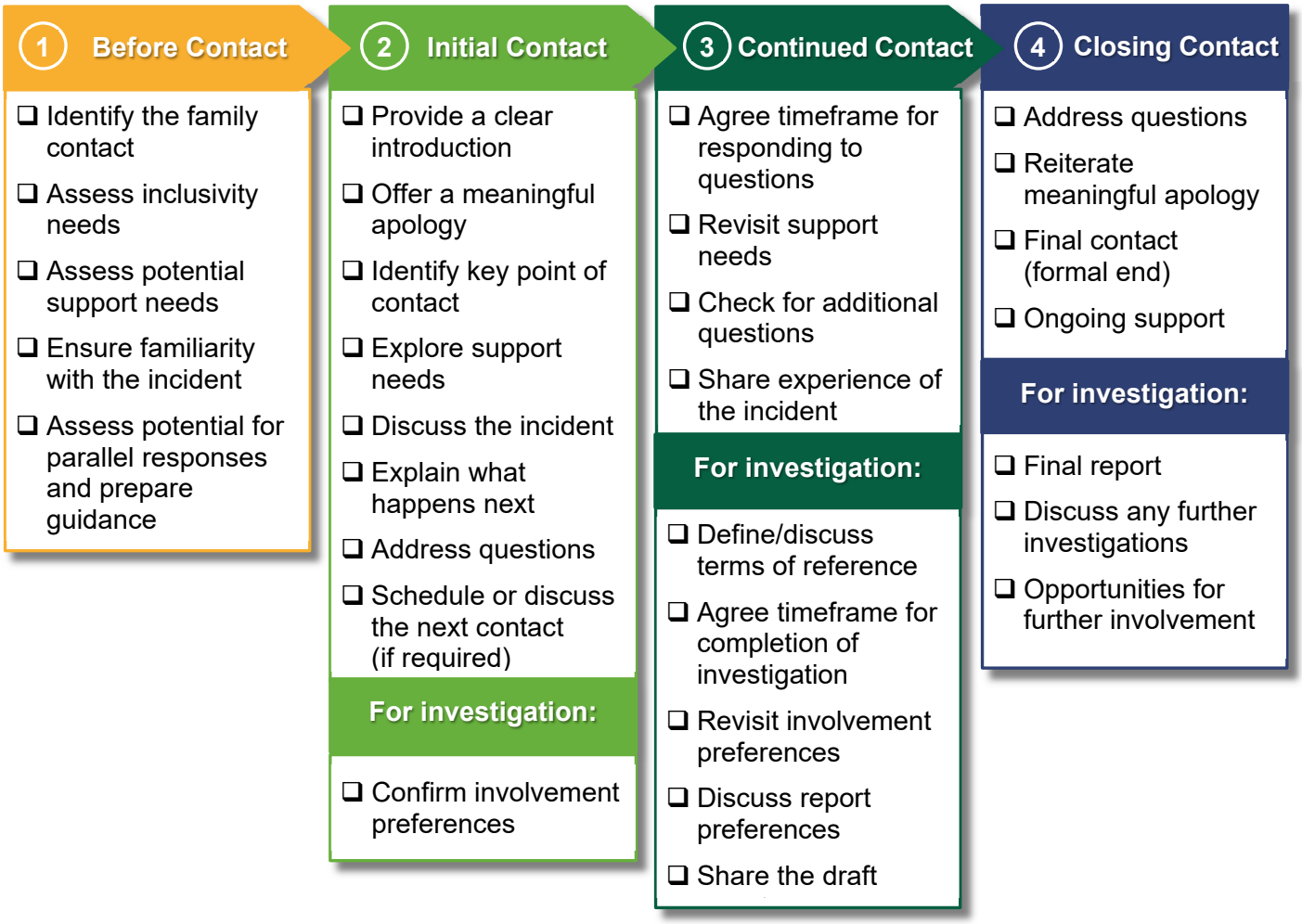
PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports developing an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have concerning the incident and signpost them to support as required.

The CSH Surrey patient experience strategy also supports and complements the continuous engagement of patients at the earliest stage when there are any concerns from patients regarding near-miss incidents that may cause dissatisfaction with the service.

CSH Surrey will adopt the four-stage support approach outlined in the document 'Engaging and involving patient families and staff following patient safety incidents' (NHS England 2022).

Fig. 2: Four steps of engaging and involving patients, staff, and families



5.1 Involving Patients, Families, and Patient Representatives

CSH Surrey is committed to involving patients and families following patient safety incidents at the earliest opportunity and throughout the ongoing investigation process.

This policy refreshes and prioritises the existing guidance relating to the duty of candour and 'being open and honest' and recognises the need to involve patients, families, and patient representatives as soon as possible. It further includes patients' families and carers in all stages of any investigation or improvement planning unless they express a wish not to be involved.

In engaging patients' families and their representatives, the CSH Surrey Duty of Candour and Being Open Policy should be always followed. It is the expectation of all clinical staff, managers, and co-owners to be open and honest with patients and their families when there are instances of harm or unintended outcomes during care. The Duty of Candour, which is a statutory requirement aims to foster trust, accountability, and learning within the healthcare system, promoting a culture of openness to improve patient safety and overall care quality.

5.2 Involving and Supporting Staff and Partner Agencies

The involvement of colleagues and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident, ensuring that there is a process of openness and transparency throughout.

Staff reporting incidents are involved from the early stages as part of the investigation to harness learning as capacity permits. Staff involved in incidents are encouraged to partake in swarm huddles and learning responses, like AAR.

Following the fair and just culture guide, CSH Surrey will continue to promote, support, and encourage incident reporting, including near misses and all levels of harm.

The first line of reporting of most incidents is the incident reporting system (Datix) which is immediately escalated to the Patient Safety Team. Once triaged, actions will be put in place as soon as possible depending on the nature of the incident to mitigate the risk.

Staff and colleagues need to feel supported to speak out and openly report incidents and concerns. They also need to be supported when they are involved in incidents.

All managers in the organisation are being provided with training to enable them to provide support for staff involved in incidents under the just culture guide.

6 CSH SURREY PATIENT SAFETY INCIDENT RESPONSE PLANNING

Our plan sets out how CSH Surrey intends to respond to patient safety incidents for the next 12-18 months. The plan is not a permanent set of rules that cannot be changed.

We will remain flexible and consider the specific circumstances in which each patient safety incident occurred, the needs of those affected, and the plan.

6.1 Resources and Training to Support Patient Safety Incident Response

Clinical governance and patient safety training is part of our corporate induction to ensure all staff are aware of this document and other governance policies and their responsibilities for reporting incidents via our incident reporting system, Datix.

In-house training is conducted to support managers and staff in managing incidents. Existing members of staff were provided with additional training before transitioning to the Learn from Patient Safety Event (LFPSE) service.

Training requirements for all staff relevant to PSIRF and patient safety are summarised in Table 1.

Table 1: Training requirements for patient safety and PSIRF

General	Course/Topic	Staff Group/Role	Training available	Provider
Induction and ad hoc	LFPSE Datix and introduction to PSIRF	All staff on induction **(once at induction or when required)**	Face-to-face or MS Teams training	Patient Safety and Team and Effectiveness Team
Patient Safety Syllabus	Level 1 – Essentials of patient safety for all staff	All staff	ESR (Electronic Staff Record)	Health Education England
	Level 1b – Essentials for Patient Safety for Board and Senior Leaders	Board and Senior Managers		
Patient Safety investigation Training for Strategic Decision Makers	PSIRF Oversight training	Board and Senior leaders / strategic decision makers	Booking via HSSIB	HSSIB
PSIRF in-person training or online course	A systems-based approach to an incident investigation (in person)	Lead investigators	One day and ongoing support	HSSIB and in-house
	Involving those affected by patient safety incidents in the learning process	Engagement Leads	In-house and Support	HSSIB and in-house
After Action Review (AAR)	Incident Investigation via AAR involving safety culture	Staff members who will be responsible for facilitating AARs For example: • Patient Safety Team • Matrons • Subject Matter Experts, e.g., for: ○ Falls ○ Infection Control ○ Tissue Viability ○ Medicine Management	Face-to-face with train the trainer	ITS AAR for conducting development and training the trainers. In-house training

6.2 Our Patient Safety Incident Response Plan

Our Patient Safety Incident Response Plan is not just a document but a dynamic, 'living' guide that evolves as we actively respond to patient safety incidents. As we utilise and learn from it, we are committed to making timely amendments and updates to ensure its relevance.

6.3 Reviewing Our Patient Safety Incident Response Policy and Plan

In 12-18 months, we will conduct a comprehensive review of our PSIRF plan and policy, ensuring that our focus aligns with the current landscape. Given the nature of continuous improvement efforts, we anticipate shifts in our patient safety incident profile. This review also presents an invaluable opportunity to re-engage with stakeholders, fostering open discussions to collaboratively agree on any changes made in the preceding 12-18 months.

Once approved by the Board, the updated plan will be presented to the ICB and promptly published on our website, replacing the previous version. Responsibility for the review of this policy lies with the Head of Quality Governance.

7 RESPONDING TO PATIENT SAFETY INCIDENTS

7.1 Patient Safety Incident Reporting Arrangements

Established mechanisms are in place to allow staff, patients, and the public to record patient safety incidents. The organisation has the capacity in the Patient Safety Team for daily reviews of incidents and to coordinate weekly incident review meetings and quarterly learning events.

There is an added capacity within the organisation to undertake 5-10 patient Safety Incident investigations (PSIIs) in the 12-18-month period of this plan (allowing time for our teams to adapt to the new methodology of System Engineering Initiative for Patient Safety (SEIPS) and the varying complexity of the patient safety investigations. A range of other responses has been rolled out in the organisation for which appropriate training has been rolled out.

a) CSH Surrey incident reporting system, Datix

Most of our incidents are reported through the Datix system, which has now transitioned to include the Learn from Patient Safety Events (LFPSE). It is recognised that staff must continue to feel supported and able to report any incidents or concerns about patient safety whilst promoting a system of continuous improvement within a fair and just culture.

Incidents reported via the incident reporting system are escalated immediately to the relevant people, usually the line manager and key members of the team in the service where the incident occurred. All incidents reported are triaged by the Patient Safety Team and evaluated for appropriate response.

Feedback is provided to staff who report incidents and to the staff and patients affected by incidents and serious incidents. All staff involved in incidents are supported and treated according to just culture principles.

b) Complaints process via the Patient Experience Team

Complaints involving patient safety incidents are transferred to the incident section of Datix and reported as incidents. The Patient Experience Team and the Patient Safety Team engage and involve the patient, families, and staff involved in incidents originating from complaints as soon as possible via the patient experience strategy and the principles of this policy.

c) Patient Advice and Laison Service (PALS)

The public can report incidents through the PALS system in NHS organisations.

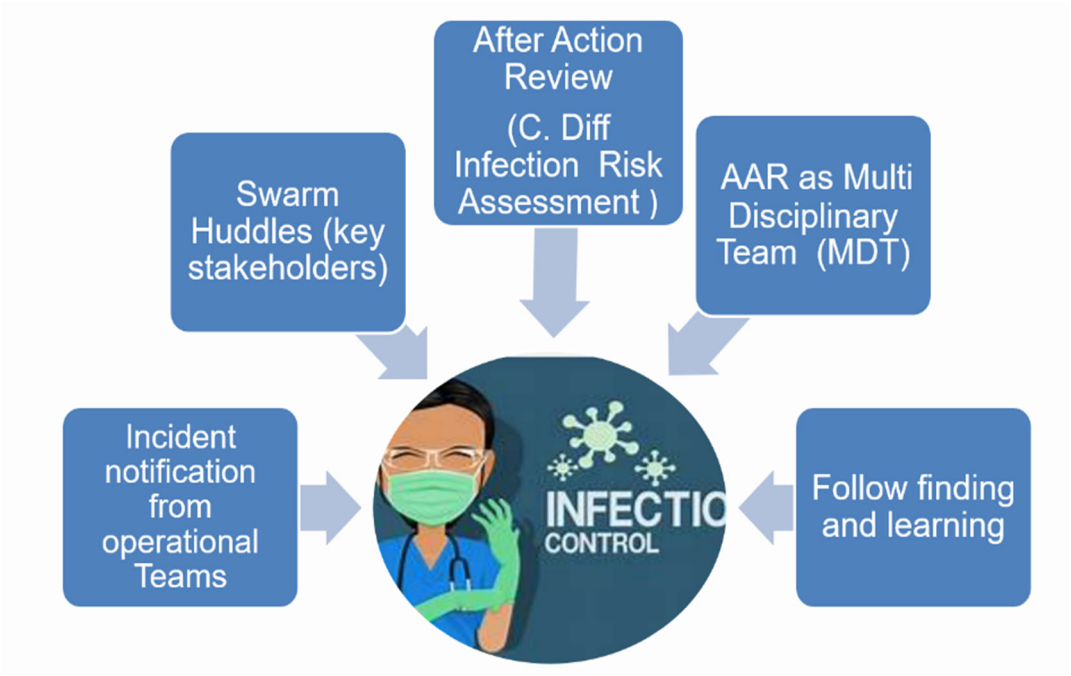
d) Freedom to Speak Up Process

Staff can report concerns relating to patient safety to the Freedom to Speak Up Guardian and the Voice if safety concerns are not adequately addressed.

Information from patient safety incidents, safeguarding, complaints, and Freedom to Speak Up reports is triangulated to ensure risks are identified and responded to most effectively, regardless of how they were first raised or reported.

e) Response to infection prevention and control incidents

In response to the transition of CSH Surrey to PSIRF, the current rules governing responses to Healthcare Acquired Infections (HCAI) through a Post-Incident Review (PIR) will no longer apply. Instead, suspected HCAIs will be addressed through an After-Action Review. In cases of infection outbreaks, a thorough outbreak review will be conducted. This strategic shift ensures a more dynamic and effective approach to managing infection prevention and control incidents, aligning with our commitment to continuous improvement and patient safety and PSIRF.



f) Response to safeguarding adult incidents and Section 42 investigations

Presently, the Safeguarding Adults Team contributes to inquiries from the local authority. When concerns are raised by external bodies such as families, district nurses, or care homes, the local authority, under the Care Act 2014, is duty-bound to obtain information about those concerns and investigate them.

The inquiry stage involves gathering information to determine if the concerns meet the threshold for a Section 42 investigation to be conducted. Learning is emphasised when there are lessons to be learned, and feedback is provided to the local authority to ensure that learning has been acknowledged.

If the Section 42 investigation is substantiated and the patient or family is dissatisfied with the response or actions from the organisation, a strategy meeting will be convened involving key stakeholders including social workers, police, healthcare professionals, educational professionals, legal representation, etc.

As part of our national priority, CSH Surrey will manage incidents in line with the recommended national guidance. However, to facilitate immediate learning Safeguarding incidents of concern will be immediately responded to via the weekly Incident Review Panels and at the Quality and Clinical Governance Group.

Actions can be escalated to the quarterly learning event to be shared at an organisational level. When the investigation is completed by adult social care any actions are shared at the relevant panels.

g) Responding to cross-system incidents

We actively collaborate with local and national partners at all levels through various engagement avenues. We interact with the ICB at our weekly and monthly Investigation Review group, at our quarterly learning event, 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. Incidents reported on Datix that involve other organisations are flagged to local partners or via the ICB.
This encourages a more cohesive and effective method of learning from incidents that are cross-system.

CSH Surrey participates in joint investigations to facilitate learning. Our Datix system is now fully transitioned to Learn from Patient Safety Event (LFPSE) in readiness to facilitate sharing of incidents with our partners and other organisations.

National incident reporting is a fundamental aspect, aligning with our commitment to national priorities as highlighted in the Patient Safety Incident Response Plan (RM 07), 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 incident management pyramid, 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.

7.2 Other Incident Reporting Arrangements

a) Coroners' Inquests

Deaths of patients can be reported to the coroner. If CSH Surrey has been involved in the care of patients and becomes aware of the death either by the coroner or otherwise, such an incident will be investigated as a safety incident and investigated via the appropriate response mechanism.

b) Care Quality Commission (CQC)

CQC reportable incidents can be reported to the CQC by CSH Surrey staff or members of the public, which CSH Surrey can investigate.

7.3 External Reporting

There is a requirement to report incidents from the organisation to external bodies, such as:

- Care Quality Commission (CQC)
- Deaths are reported to the coroners directly or via medical examiners.
- National Health Service England (NHSE)
- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)
- Health and Safety Executive (HSE) for patients involved in reporting of injuries
- Reporting of Injuries, Diseases, Dangerous Occurrence Regulations (RIDDOR) incidents
- NHS Digital and the Information Commissioner's Office (ICO) for information governance (IG) items
- Medicines and Healthcare Products Regulatory Agency (MHRA)

7.4 Internal Stakeholders for Incident Reporting and Investigation

- Medicines Management Team (Medication Safety)
- Falls Prevention Team
- Insulin and Diabetes Team
- Infection Prevention Control Team
- Tissue Viability Team
- Information Governance Team
- Safeguarding Team (Adults and Children)
- Health and Safety Lead
- End of Life Team
- Patient Experience Team
- Executive Team
- Children Services
- Adult Services
- Freedom to Speak Up Guardian

7.5 Patient Safety Incident Response Decision-Making

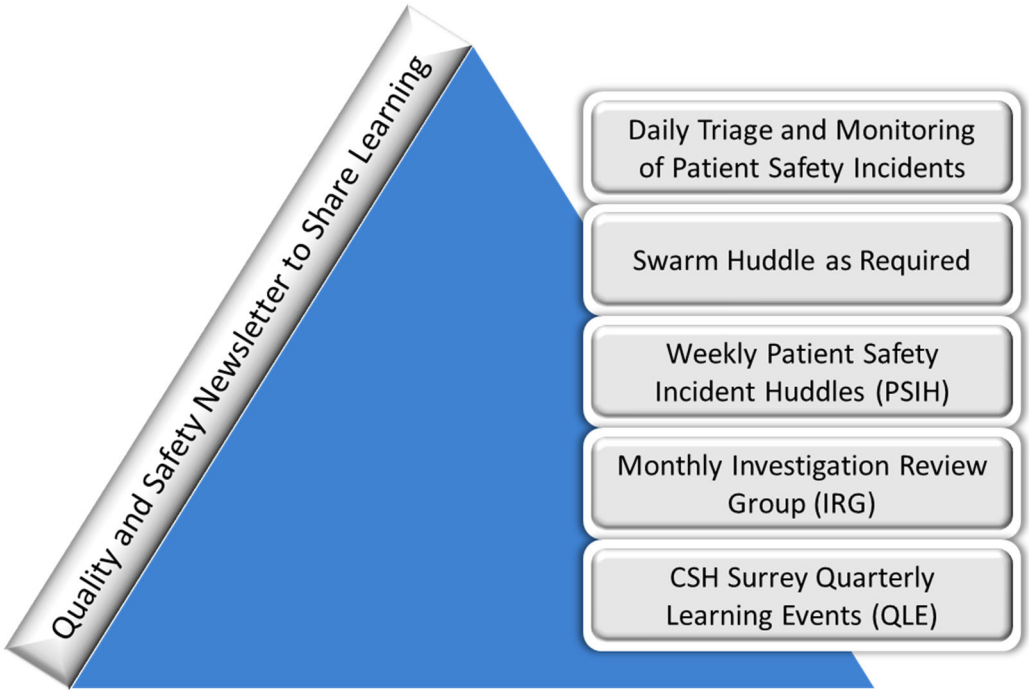
CSH Surrey has governance and assurance systems to ensure oversight of incidents reported within the organisation. All incidents reported via the incident reporting system (Datix) are triaged to assess the potential harm to the patient and the risk of further injury.

7.6 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 also reviewed daily by the Quality and Governance Team.

All incidents identified for discussion are escalated to the weekly Patient Safety Incident Huddles.

Fig. 3: CSH Surrey learning and improvement pyramid



7.7 Swarm Huddle

If a patient safety event requires immediate urgent action, swarm huddles will be conducted to provide quick actions and avert patient risk. Swarm huddles should be held within twelve hours of the incident or as soon as possible. Staff involved, their line manager, the manager of the area where the incident occurred, and the Patient Safety Team will participate in swarm huddles. The level of participation depends on the nature of the incident.

7.8 Incident Review Meetings

a) Weekly Patient Safety Incident Huddles (PSIH)

Reported incidents are triaged and reviewed by the Patient Safety Team to identify and group incidents according to our patient safety priorities. At PSIHs, we confirm the level of harm of patient safety incidents, support required for staff and patients (Duty of Candour), immediate actions, incident response plan, lead for response, and who should be involved. The ICB is invited to our weekly, monthly, and quarterly meetings.

b) Investigation Review Group

This monthly meeting is where all incidents CSH Surrey investigates are signed off. This meeting will be 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 to inform the quality improvement agenda. Actions and outcomes are escalated to the Board and executive as well as to the ICB.

c) Quarterly Learning Events

At the quarterly learning event, CSH Surrey explores the opportunity to learn and showcase improvements and learning from patient safety incidents. 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.

d) Timeframes for Learning Responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible with thoroughness and sufficient time and resources to identify the critical contributory factors and associated learning for improvement. The PSIRF plan, as detailed above, indicates the types of learning response most appropriate to the circumstances of the incident. All patient safety incidents that require investigation per our local plan are reviewed either during our weekly huddle or immediately in a swarm huddle, based on the risk of the incident to patient safety, and reported in relevant forums.

A learning response is agreed upon with the timeline and lead investigator at the huddle. Incidents investigated following After-Action Review (AAR) methodology should be completed within one calendar month and presented at the next Investigation Review Group meeting. Comprehensive investigations and thematic reviews will be expected to be completed between 60 - 120 working days, depending on the complexity. Exceptions shall be approved by the medical director and the Director of Quality and Chief Nurse.

7.9 Safety Action Development and Monitoring Effectiveness of Safety Actions

PSIRF moves away from the identification of 'recommendations', which may lead to determining a resolution at an early stage of the safety action development process. All investigations will be reported via the specific response template (detailed in the appendix, pages 21-36) to provide summaries of all safety actions.

The safety actions arising from a learning response should follow the SMART (specific, measurable, achievable, realistic, time-bound) principles, and thought must be given to monitoring and measures of success.

Safety actions must be developed with the clinical and operational teams that will implement these actions to ensure ownership of the outcomes. Services will identify appropriate measures, with support from the Quality & Governance Team, to test the effectiveness of any planned actions. Actions are then regularly reviewed using these measures to evaluate their impact and determine whether these should be adapted, adopted, or abandoned.

The effectiveness of each action originating from investigations will be tested through a range of methodologies. Examples of methodologies to test the effectiveness of SMART actions are summarised in Appendix 2 of this policy.

It is important that monitoring of completion of safety actions does not become an end, but rather a means to improve safety and quality outcomes and reduce risk. CSH Surrey will develop systems focused more on measuring and monitoring these outcomes using a combination of quantitative and qualitative information, utilising subjective as well as objective measures.

Monitoring of completion and efficacy of safety actions will be done through QI and clinical governance processes. The Patient Safety Team will maintain an overview across the organisation to identify themes, trends, and triangulation with other sources of information that may reflect improvements and reduction of risk.

Safety actions must continue to be monitored within services and local governance arrangements to ensure that any actions put in place remain impactful and sustainable. Local reporting on the progress with safety actions, including the outcomes of any measurements, will be made to the quarterly learning events and the monthly Quality and Clinical governance group meeting.

All patient safety incidents will be managed via appropriate learning responses. Learning response methods enable the collection of information to acquire knowledge. CSH Surrey's integrated process for designing, implementing, and monitoring safety actions will limit attempts to reduce risk and potential harm. Quality improvement to support embedded learning and improvement following a patient safety investigation is critical to improving patient safety outcomes. The completion and effectiveness of safety actions will be monitored through organisational governance processes.

7.10 Other Methods of Enhancing Safety and Evaluating Effectiveness

Evaluating the effectiveness of our ongoing improvement efforts entails a comprehensive approach that integrates various data sources to ensure a robust assessment.

Firstly, we employ triangulation by scrutinising data from NHS staff surveys, with a specific focus on identified actions. This approach enables us to cross-reference insights from multiple perspectives within our healthcare system, thereby enhancing the validity of our findings and improvement over time.

Secondly, we leverage local and national clinical audits directly linked to actions derived from our patient safety investigations. This interconnectedness ensures that our improvement initiatives align with broader quality assurance processes and industry standards.

Additionally, we conduct periodic thematic reviews in alignment with our patient safety plan. These reviews provide a structured examination of overarching themes, allowing us to gauge the overall impact of our safety measures and identify areas for continuous enhancement. In addition to data generated from our processes, information from other sources contributing to safety, such as National Patient Safety Alerts, are promptly implemented with recommended actions fully executed.

This approach aims to establish a comprehensive and multifaceted evaluation framework that informs and strengthens our commitment to sustained improvement over time. Progress against the highlighted improvements is periodically reported to the Quality and Safety Committee, the Board, and the ICB.

7.11 Safety Improvement Plans

The Patient Safety Incident Response Plan (PSIRP) clarifies CSH Surrey's improvement priorities. The PSIRP details how we will investigate patient safety incidents more holistically and inclusively, using just culture to identify learning.

The PSIRP details how the organisation will investigate patient safety incidents holistically and inclusively to identify key learning and safety actions that will reduce risk, improve safety and quality of services, and improve patient safety outcomes. The organisation will continually review its governance processes in line with the PSIRF guidance, so it is clear how the PSIRP improvement priorities will be overseen through its governance processes to provide assurance.

The themes detailed in the PSIRP plan to formulate our local priorities are based on an extensive analysis of historical data and information from various sources, e.g., incident trends, complaints, mortality reviews, Patient Advice and Liaison Service (PALS) records, and inquests. Each theme will have an improvement workstream using quality improvement (QI) methodology to determine the key drivers for patient safety risks, how improvements can be made, and how these are monitored and reported for completion and effectiveness. Sharing of learning will be conducted via our quarterly learning events and CSH Surrey Quality newsletter.

8 OVERSIGHT ROLES AND RESPONSIBILITIES

CSH Surrey will work with the Surrey Heartlands ICB for oversight arrangements and ensure active participation within local networks. CSH Surrey is committed to close working, in partnership, with the Surrey Heartlands ICB and other national commissioning bodies as required. Representatives from the ICB will be invited to sit on our Investigation Review Group. The ICB and CSH Surrey will mutually agree on the progress of PSIRF and the review of this policy.

Oversight and assurance arrangements will be developed through joint planning and arrangements and incorporate the critical principles detailed in the guidance, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning, and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement under PSIRF: there is a paradigm shift from monitoring processes, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

The ICB will oversee PSIRF plans/priorities and monitor progress with improvements. There will no longer be a requirement to 'declare' a serious incident (SI) and have individual patient safety responses signed off by the ICB. The internal process for learning and investigating patient safety incidents is enshrined in this policy. The processes including the selection of incidents, type of investigation, and learning from patient safety incidents are detailed in relevant sections of this policy and the PSIRF Plan.

Following the necessary training and capacity building, the responsibilities of PSIRF will lie on the following groups and individuals:

CSH Surrey Board

The Board is responsible for ensuring that it receives assurance that this policy and the PSIRF Plan are being implemented, lessons are being learnt, and areas of vulnerability are improving. This will be achieved through reporting processes and receiving assurance via the Quality and Safety Committee.

The CSH Surrey Board receives quarterly reports on the progress of the implementation of PSIRF. Once PSIRF is fully implemented, the Board will receive quarterly reports on patient safety incident investigations with the quality improvement progress via the Quality and Safety Committee and their reporting groups.

Where concerns are identified relating to the systems and processes in place to achieve required improvement, the CSH Surrey Board will seek assurance that these concerns are being acted upon.

Chief Executive

The Chief Executive is responsible for providing appropriate policies and procedures for all health and safety aspects (Health and Safety at Work Act 1974). As part of this role, the Chief Executive is responsible for ensuring adequate risk management systems and processes are in place to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff, and visitors. The Chief Executive is ultimately responsible for ensuring all investigations are handled effectively and appropriately.

Director of Quality and Chief Nurse

The Director of Quality and Chief Nurse is the executive lead for PSIRF with the responsibility to effectively monitor and oversee PSIRF and ensure that systems and processes are in place for oversight of patient safety reporting and review (including governance arrangements, staff support, and training).

The Director of Quality and Chief Nurse is responsible, with the Company Secretary, for reporting to the Board, providing assurance that the PSIRF policy/protocol sets out how the framework will be achieved in practice, and working with the Director of People to ensure that PSIRF's aims are embedded into the organisation's culture.

Patient Safety Partners

As part of our commitment to working with members of the public, we have a partner program in place. This is where members of the public join our Quality and Safety Improvement work. Those who partner with us have expectations as part of their contribution to the PSIRF:

- To undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus and other relevant training
- To participate in investigation oversight groups and be active members of the PSRIF QI workstreams and other work streams to help us design safer care systems and prioritise risk
- To encourage patients, families, and carers to play an active role in their safety
- To contribute to action plans following investigation, particularly around actions that address the needs of patients
- To contribute to staff-patient safety training. In working with us to achieve safety, the PSPs are accorded protection for other staff members

Head of Quality Governance and Patient Safety Specialist (HQG&PSS)

Provides expert support for patient safety to the organisation and the Executive Team, and facilitates the escalation of patient safety issues or concerns. HQG&PSS is responsible for implementing the patient safety strategy, including developing a patient safety culture, safety systems and improvement activity.

The HQG&PSS will support training for various aspects of PSIRF, including After Action Reviews and other investigation processes.

The HQG&PSS is the champion of just culture and challenges a way of working to focus on learning and supporting staff.

As well as coordinating and supporting local patient safety priorities, HQG&PSS helps implement the NHS patient safety strategy and other national safety priorities. They have close links with the NHS England National Patient Safety Team, which hosts a national network for patient safety specialists, including regular meetings and information sharing through a dedicated online forum.

The critical role of HQG&PSS during and after the implementation of PSIRF is to lead patient safety education and the patient safety syllabus.

HQG&PSS manages the Patient Safety Team and Patient Experience Team, and engages and collaborates with key internal and external stakeholders such as the county safeguarding team, education institutions, ICB, and other local organisations via the patient safety specialist network.

All Staff

All staff are encouraged to highlight any risk issues that warrant further investigation. Training is provided to staff at induction for incident reporting.

Staff should be fully open and cooperative with any patient safety review process. All staff must know and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the risk management pages of Blink.

Patient Safety Incident Investigators (PSIIs)

- Will have specialist training to support the investigations of patient safety incidents
- Ensure that PSIIs are undertaken in line with the national PSII standards
- Ensure that they are competent to undertake the PSII assigned to them, and if not, request it to be reassigned
- Should be competent in formulating SMART actions from PSII to feed into QI workstreams
- Provide liaison with patients and families subject to a patient safety incident investigation

Being Open Leads

- Are responsible for ensuring the organisation’s legal duty of candour is discharged for appropriate incidents
- Identify those affected by patient safety incidents and their support needs by being the single point of contact
- Facilitate their access to relevant support services

- Obtain information from the review / Patient Safety Team to help set expectations
- Work with the Patient Safety Team and other services to prepare and inform the development of different support services

9 COMPLAINTS AND APPEALS

Any complaints relating to this guidance, or its implementation can be raised informally with the CSH Surrey Patient Safety Specialist, initially, who will aim to resolve any concerns as appropriate.

10 TRAINING AND RELATED COMPETENCY TOOLS

Please refer to Table 1 in section 6.1.

11 MONITORING OF COMPLIANCE

11.1 Associated Audits and Quality Assurance

Audits and quality assurance process around this policy will be generated from the test of effectiveness (Appendix 2).

12 DISSEMINATION AND IMPLEMENTATION

All new recruits to CSH Surrey will be informed through their induction that all policies and procedures are available in the Blink.

13 ASSOCIATED DOCUMENTS AND REFERENCES

13.1 Related Statutes or National Regulations

1. Patient Safety Incident Response Framework (NHS England) https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

13.2 Related NICE Guidance

There is no NICE guidance related to this document.

13.3 Related CSH Surrey Documents

	Title	Ref
1	Patient Safety Incident Response Plan	RM 07
2	Risk Management Strategy	RM 02
3	Duty of Candour and Being Open Policy	CG 01
4	Improving Patient and Carer Experience Strategy	CG 07

14 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

Appendix 1 A: CSH Surrey After Action Review Template

After Action Review (AAR)

What is it?

An After-Action Review (AAR) is a method of evaluation that is used when the outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid errors and promote success for the future. It is a structured approach for reflecting on the work of a group and identifying strengths and areas for improvement. This method of evaluation usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, which can then be shared more widely.

After Action Review Report Title:		
Incident Date:	**Date reported:**	**Datix Ref:**
Author (name and role):		
Venue for AAR		
Date and Time of Report		
AAR Conductor		
Participants of AAR		

Incident description and consequences:	
Brief description of Incident and relevant background of patient	
Incident date	
Incident type	
Service	
Actual severity of the Incident	
Is the patient involved in the AAR?	

Are there any safeguarding concerns?	
Support for family/carer, patient, and staff in place?	

AFTER ACTION REVIEW TERMS OF REFERENCE AND QUESTIONS FOR DISCUSSION
Summary of what was expected (As discussed in AAR)?
Summary of what actually happened (As discussed in AAR)
Summary of why was there a difference?
What can be learned (Key learning Point)
What went well
Detection of Incident
Recommendations

No	Safety Action	Test of effectiveness	Responsible Person	Date for completion
	Specify action required	*Detail what assurance will be provided of completed action*	*Name, job title*	*Date to be added*
1.				
2.				

Appendix 1 B: CSH Surrey Swarm Huddle Template

Incident reference:		**Incident date:**	
Incident description:			
Swarm reference		**Swarm date and time**	
Swarm facilitator name:		**Facilitator role:**	
DOC status:			
Attendees:			

Specific issue to be addressed by the swarm:	

What is it: *A meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened; how it happened; and decide what needs to be done immediately to reduce risk. It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely. Safe space, invitees only (those involved in incident, agreed by the directorate/Patient Safety Team).* **When to use it:** *Swarms can be used soon after any activity or event (within a working week ideally) where care has not gone as planned - this can prevent key information from being lost. Swarms can reduce blame and rumours about an incident by focussing on learning and improvement and an understanding of 'work as done'.*	
Introduction and create a safe and 'brave space'	
Facilitator to introduce all participants and their role in the Swarm	
Explore exactly what happened and why	
Replay the events that led to the	
Explore what happened and why; use the systems work prompts.	

Identify where else in the organisation the learning may be relevant	
Are there any other services or directorate where this learning needs to be shared?	
How you are going to share the learning more widely and who will take responsibility for this?	
Safety actions to be carried forward	
System Improvement Plan/Immediate Safety Actions to be taken with designated lead	
Does this contribute learning or confirm actions in any overarching safety improvement plan	

Date reviewed and approved at Directorate Patient Safety Panel	
Actions/next steps agreed	

Appendix 1C: CSH Surrey Patient Safety Incident Investigation (PSII) Report Template)

Distribution List

Incident ID number:	
Date incident occurred:	
Report approved date:	
Approved by:	

Contents

To update this contents table, click on the body of the table; select 'update field;' and then 'update page numbers only;' and then click 'ok'.

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability, or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks, and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers, and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families, and staff following a patient safety incident guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the just culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

Executive summary

Incident overview

Summary of key findings

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary

Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by the development of a safety improvement plan.

Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.

Areas for improvement and safety actions must be written to stand alone,

Use plain English and avoid abbreviations, acronyms, and jargon, unless absolutely necessary.

Refer to the Safety action development guide for further details on how to write safety actions.

NB: The term ‘lesson learned’ is no longer recommended for use in PSIIs.

Background and context

Notes on writing about background and context

The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist in understanding of the incident.

It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.

It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event

The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.

Think about how best to structure the information – e.g., by day or by contact with different services on the care pathway.

It should be written in neutral language, e.g., 'XX asked YY' not 'YY did not listen to XX'. Avoid language such as 'failure', 'delay', and 'lapse' that can prompt blame.

If the patient or family/carer has agreed, you could personalise the title of this section to '[NAME]'s story/experience'.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (e.g., via organisation's reporting system)
- how agreement was reached to investigate the incident (e.g., review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (e.g., final report approved by whom)?
- how actions will be approved and monitored, and who will agree that they can be closed

Terms of reference

Notes on writing about the scope

In this section, you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation.
- questions raised by those affected that will be addressed by the investigation.

If those affected by the patient safety incident (patients, families, carers, and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families, and staff following a patient safety incident guidance.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (e.g., the investigation considered how factors such as the environment, equipment, tasks, and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, e.g., medical records, staff rosters, guidelines, standard operating procedures (SOPs)
- any other methods.

Recorded reflections, e.g., those used for learning portfolios, revalidation, or continuing professional development purposes, are **not suitable** sources of evidence for a system focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings.

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate and evidence your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the 'how' the incident happened, not the 'what' and 'when'.

Start with an introductory paragraph that describes the purpose of the section and the structure you are going to use.

For your findings to have an impact, you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first.
- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, e.g., community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, e.g., 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader system issues related to the wider organisational context are best addressed in a safety improvement plan. You should describe what the next stages are with regard to developing a safety improvement plan that will include meaningful actions for system improvement.

Summary of findings, areas for improvement, and safety actions

Notes on writing the final summary.

The purpose of this section is to bring together the main findings of the investigation.

Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).

If no actions are identified, the safety action summary table is not required. Instead, you should describe how the areas for improvement will be addressed (e.g., refer to other ongoing improvement work, development of a safety improvement plan)

Safety action summary table

Area for improvement: [e.g., r*eview of test results*]

	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Test of effectiveness	Measurement frequency *(e.g., daily, monthly)*	Responsibility for monitoring/ oversight *(e.g., specific group/ individual, etc)*	Planned review date. *(e.g., annually)*
1.								

Area for Improvement: [e.g., *nurse-to-nurse handover*]

	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Test of effectiveness	Measurement frequency *(e.g., daily, monthly)*	Responsibility for monitoring/ oversight *(e.g., specific group/ individual, etc)*	Planned review date. *(e.g., annually)*
1.								

Appendix 2. Examples of Methods for Monitoring Compliance and Test of Effectiveness of Improvement Actions

Methodology of testing for effectiveness	Examples of improvement action for which effectiveness is required	How will effectiveness be monitored
Prospective/Concurrent audit of skill delivery, e.g., observation audit of injecting insulin.	Clinical skills or physical skills	Data collected via clinical supervision or peer reviews (monthly or quarterly) to feedback effectiveness.
Retrospective audits of procedures to collect data on the effectiveness of the procedure	Process improvement, or process changes	Quarterly/monthly audits of random records as part of the local audit process.
Observational Audit	Physical skills like hand washing and clinical skills	An audit where processes are observed and recorded, e.g., Hand washing, IV care, use of Red Trays, etc.
Direct Monitoring	Suitable for all improvement processes	Ongoing data collection to establish levels of performance.
Benchmarking	Process changes and comparison of practice following improvement	Comparison of data collected from one service to another once required actions have been completed.
Record Keeping Audit	Documentation of clinical processes or policy changes	Continuous monthly documentation audits of various parameters following improvement actions.
Structured Interviews	Satisfaction of patients or colleagues about improvement	Structured interviews, face-to-face or telephone calls with patients or staff about their views on improvement
Patient Experience	Satisfaction of patients about improvement	Survey/questionnaire to elicit patient views.
Performance Indicators	Performance of tasks	Measuring practice against pre-defined criteria or targets.
Point Prevalence	Skills and process change	An audit looked at a process/event for all wards/departments on a given day. This is useful to show trends.

Methodology of testing for effectiveness	Examples of improvement action for which effectiveness is required	How will effectiveness be monitored
Structural Audit	Most improvements	Auditing use of resources, e.g., staff numbers, skill mix, organisation, space, and equipment.
Process Audit	Improvements in processes like communication, education, medication	Auditing the actions and decisions taken by clinicians. These may include communication, assessment, education, investigations, prescribing, and other therapeutic interventions, evaluation, and documentation.
Criterion Audit	Collecting data for predetermine criteria	Auditing against explicit and agreed criteria.
Adverse Events Audit	Clinical skills improvement like falls and pressure ulcer care improvement process	Auditing of poor care or outcomes can be identified from an Incident Reporting system.
Mortality Audit	Actions arising from mortality reviews	Auditing of all deaths, often related to a specific condition.
Qualitative	Patient / staff satisfaction with the effectiveness of the procedure	This is data concerned with words rather than numbers; involves views and description of views.
Quantitative	Data collection around most improvement processes	This is an audit concerned with numerical data.
Focus Groups	Test views of staff, patients, and public following improvements	Used to obtain patients' and staff views, can use semi-structured questions.

Equality Impact Assessment Tool

Equality statement

This document demonstrates a 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.