Wirral University Teaching Hospital NHS Foundation Trust

Policy Reference: 387

Patient safety incident response policy

Version: 3

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Target Audience:	All Trust staff		
Links to other Policies, Strategies, Procedures etc.	• PSIRF Plan • Duty of Candour and Engagement Policy • Incident Reporting and Management Policy		

Key Points for Staff

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Wirral University Teaching Hospitals NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of 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.

CONTENTS

Content **Page**

1 Introduction and Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient-facing services within the Trust.

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 the purpose of 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.

The Trust will ensure the leads for different investigation styles work together to ensure each investigation seeks to deliver the investigation's intended outcomes and complement each other rather than duplicating scope or omitting key work.

2 Oversight Roles and Responsibilities

Oversight of Patient Safety Responses will take a range of formats. Initially the policy standards will be under the oversight of Trust Board, this will be delivered through an annual report to Trust Board detailing:

- The arrangements to align patient safety response to quality improvement. This component will be delivered through the functions of the Lessons Learned Forum and will be clearly visible in the development of Quality Priorities for the Trust each year.
- The progress made towards just and learning culture, ensuring that appropriate and proportionate responses are maintained for those staff involved in patient safety incidents.
- Effective information sharing for joint working in relation to patient safety learning.
- The governance and reporting structures, along with the process to ensure all staff, patients and public are supported to engage and are treated with dignity and respect supporting openness and transparency.

The oversight of the patient safety incident response plan and delivery of patient safety incident responses will be led, internally by the Quality Committee. This oversight will primarily be delivered through the quarterly Trust Quality & Safety Intelligence Report. The Intelligence Report will describe the following standards:

- Thorough analysis of relevant organisational data.
- Collaborative stakeholder engagement via the Lessons Learned Forum.
- Clear rationale for the individual and thematic responses.
- Clarity on leadership for each response, including the skill set of the leads.
- Clarity on the Engagement Lead support provided to those effected by the patient safety incidents.
- The alignment of the learning from responses and the quality priorities and themes within the Trust.

Oversight of individual patient safety responses will be completed through the Lessons Learned Forum to seek assurance that adequate investigation, learning and action planning has taken place to allow quality improvement. In addition to the Lessons Learned Forum, all Patient Safety Incident Investigations (PSIIs) will be reviewed and approved as complete via the Executive Medical Director and/or Chief Nurse.

3 Patient Safety Incident Response Framework

3.1 Our patient safety culture

A key priority within the Trust People strategy is to embed a 'Just and Learning culture' that facilitates continuous learning, creates psychological safety which supports staff to raise and address concerns, and focuses upon good practice that is shared and replicated within and beyond organisational boundaries. This priority is very much aligned to the patient safety culture sought to deliver the PSIRF.

With regards to culture and delivery of the PSIRF, evidence of a patient safety culture will be provided through a low threshold for reporting incidents and escalating concerns allowing the greatest range of learning opportunities. This culture requires a fundamental level of psychological safety that is driven through the just and learning culture priority.

Alongside the opportunities to learn from incidents, the Trust is committed to learning from excellence and doing this through the reporting of excellence and reflecting on opportunities to make care currently considered as excellence, the future standard care within the Trust.

A final component in the patient safety culture across the Trust is that of compassion, understanding and engagement of those effected by patient safety incidents. This includes patients, their families, and the Trust staff. The engagement lead role is vital in driving the improvements for patient and families; however, this approach will also be adopted by all staff.

Further focus on just and learning culture will eliminate the second victim scenarios, where healthcare employees are impacted in their professional and personal lives from unfair treatment following patient safety incidents; and ensuring errors or omissions in care are seen primarily as an organisational responsibility.

3.2 Patient safety partners

Patient Safety Partners are a key element to ensuring successful implementation of the PSIRF within the Trust. The Trust engaged with a range of internal and external stakeholders to identify specific roles for Patient Safety Partners to support the implementation of PSIRF within the Trust, these roles will be reviewed at 12 monthly intervals to ensure they continue to provide the greatest impact for patient safety improvement within the Trust.

Roles for Patient Safety Partners focus on:

- Proportionate response to Patient Safety Incidents through their attendance at Patient Safety Chairs Steering Meeting and Patient Safety Response Planning Meeting
- Support to deliver Patient Safety Responses (as a member of an investigation team)
- Support to input into priority Patient Safety quality improvement programmes through their optional attendance at Patient Safety Quality Board

All Patient Safety Partners will be supported to access patient safety syllabus education and provided with professional patient safety supervision via the Deputy Director of Quality Governance. The aim will be to support Patient Safety Partners to transfer their individual experience and expertise to compliment the Trust patient safety response. Patient Safety Partners will be encouraged to equally challenge actions that are unlikely to, and suggest solutions that may, lead to sustainable quality improvement.

All Patient Safety Partners are invited to attend the Trust Lessons Learned Forum to share findings from review of all sources of patient safety insight, agree the priority areas for quality improvement and have oversight of the outputs from the patient safety steering groups.

3.3 Addressing health inequalities

Addressing health inequalities is an organisational priority and will feature in a range of quality improvement and quality assurance processes. Learning identified through patient safety responses under the previous Serious Incident Framework has already identified improvements required regarding support for effective communication with patients who have additional requirements due to physical disabilities, with a specific improvement required around deafness.

Patient safety responses will continue to consider health inequalities through a variety of routes. These routes will consider:

- Outcomes for patients across a range of specific characteristics to ensure any unwarranted variation is identified as an area for improvement for consideration at the Lessons Learned Forum.
- Specific support needs to encourage engagement in patient safety responses from all patients, focusing on what each person can add to the learning process and collectively removing any barriers to participation.
- During recruitment of PSPs consideration will be given to diversity and where gaps in partners with specific characteristics are identified, active recruitment will be led to ensure diversity in this key stakeholder group.

3.4 Engaging and involving patients, families and staff following a patient safety incident

The 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 the development of 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 in relation to the incident and signpost them to support as required.

All patients and families will be treated with respect, dignity, openness, and transparency at all times and including following a patient safety incident. All patient safety incidents will be reported utilising the Trust incident reporting and management system. Patients, and families as appropriate, will be provided with full details of the patient safety incident and offered support initially by the clinical team involved in their care.

Further support for patients and their families following a patient safety incident will utilise the key role of Engagement Lead. All patient safety incidents that are assessed to require further investigation (beyond a Rapid Evaluation of Care) will see an Engagement Lead identified to support the patient and family to be engaged with the investigation and learning process. For those patient safety incidents managed solely through Managerial Review support will be provided via the local clinical team.

The Engagement Lead role is fully defined within the Trust Duty of Candour and Being Open Policy, however Engagement Leads will provide a single point of contact for a patient and family during further responses to ensure they have every opportunity to input into the investigation and their unique perspective and understanding is included in the findings. The support from an Engagement Lead will vary depending on the nature of the Patient

Safety Incident Response but may include telephone calls, written correspondence or meetings and could be provided over a few days to several months.

The Engagement Leads access externally led training programme to develop into these roles. Full details and training requirements are described in the Duty of Candour and Being Open Policy.

Support for Staff following a Patient Safety Incident will initially be through line manager support but access to the Trust wellbeing support, Pastoral Support and Occupational Health will all be available. All staff who feel unfairly treated following a Patient Safety Incident will be encouraged to talk with the Trust Freedom to Speak Up lead or can talk directly with the Deputy Director of Quality Governance.

3.5 Patient safety incident response planning

The PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. The Trust Patient Safety Response Plan provides full details regarding:

- the triggers for Rapid Evaluation of Care
- Thematic Review of Patient Safety Incidents via the Patient Safety Steering Groups
- Facilitated Reflective Sessions via an After Action Review or MDT Review
- Patient Safety Incident Investigation
- All Patient Safety Responses utilise Systems Engineering initiative for Patient Safety (SEIPS) Methodology

• Resources and training to support patient safety incident response

To allow effective learning from Patient Safety Incidents and ensure actions lead to sustainable improvements, it is important to ensure those involved in the responses have adequate capacity and competency.

The Patient Safety Incident Responses will fall into four main categories:

- Rapid Evaluation of Care
- Thematic Review
- Facilitated Reflective Sessions (AAR and MDT Review)
- Patient Safety Incident Investigation

Rapid Evaluation of Care

Rapid Evaluation of Care (with the exceptions detailed below) will be conducted as soon as possible following a Patient Safety Incident and within 5 working days of Managerial Review. The Rapid Evaluation of Care will be led by a Clinical Director, Clinical Lead, Medical Governance Lead, alternative Consultant (trained in the technique), Associate Director of Nursing (ADN) or Matron. Divisional Clinical Governance Teams will support the production of associated reports.

Training for Rapid Evaluation of Care will be completed via an internal Trust training course led by the Governance Support Unit. All Clinical Directors, Clinical leads, Medical Clinical Governance Leads, additional nominated Consultants, ADNs and Matrons will access this training.

The Rapid Evaluation of Care is designed to be rapid and should involve a meeting of around 30 minutes. This should allow clinical discussion of the case and consideration of key elements of care and the standards of these key elements. To allow an efficient and timely meeting the attendees should have prior knowledge of the case and include appropriate clinical expertise to draw conclusions.

Rapid Evaluation of Care (REC) review of IPC incidents for C Difficile and blood stream infection incidents takes place in a weekly meeting. The meetings use adapted REC paperwork to review each incident and collate thematic findings of the reviews for Lessons Learned Forum and Infection Prevention Control Group. The multi-disciplinary meeting comprises divisional governance leads, a representative from the Patient Safety, Risk and Clinical Effectiveness Team, Infection Prevention Control team and Pharmacy.

Pressure ulcers are reviewed by a manager using a review questionnaire that has been added to Ulysses. The questionnaire will highlight the pressure ulcers that require further investigation using a Rapid Evaluation of Care. These are category 3 or unstageable, category 4 and when the manager's assessment highlights that there has been at least moderate harm impact to the patient from other pressure damage.

Falls are also reviewed by a manager using a review questionnaire that has been added to Ulysses to assess if a Rapid Evaluation of Care is required. The questionnaire includes a request for detail if the patient has experienced multiple falls and is therefore at higher risk of harm. The completed questionnaire highlights if a Rapid Evaluation of Care is required; otherwise, incident themes and learning inform the falls steering group to support the Trust's overall Falls Prevention plan.

There is scope for other incidents of a similar nature to have an initial review using a built-in questionnaire to Ulysses. These will be considered and assessed. The PSIRF plan will be updated as required.

There is the option of a Multi-Case Rapid Evaluation of Care process. This will be applied to cases of a similar nature where previous Rapid Evaluation of Care reviews have identified previously known learning. The multi-case Rapid Evaluation of Care is designed to proportionately evaluate similar cases, identify recurrent learning for ongoing thematic review but also provides the opportunity to identify new learning for further individual response if required.

Thematic Review

For incidents of reoccurring type or with reoccurring errors or omissions a thematic review will be completed via a patient safety steering group, further details on these groups are available within the Patient Safety Incident Response Plan. Thematic reviews will be completed and presented to the Lessons Learned Forum at a frequency agreed within the Lessons Learned Forum workplan and of no less than once per year.

The Thematic Reviews will be completed through the steering groups and led by the steering group chairs.

Facilitated Reflective Sessions

Facilitated reflective sessions will be an option for further investigation and decided through the Patient Safety Response Meeting. These responses will be completed within 6 weeks and reports submitted within a further 2 weeks. These sessions will be co-led by a Clinical Leader and a Clinical Governance Team member from within the aligned division(s).

Training will be completed via an internal Trust training course led by the Governance Support Unit. All Clinical Leaders and Clinical Governance Teams will access this training.

The methodology for Facilitated Reflective Sessions will utilise the national descriptions of After Action Review or MDT Review. Sessions will be aimed at around 1 hour and attendees will be provided with at least 4 weeks' notice of the session. For effective reflection these sessions will aim to include a wide range of multi-professional staff both involved in the incident and involved in the general aspects of work discussed.

The After Action Review will focus on the patient journey and care provided, reviewing the specifics for this patient's care. This may include a range of different aspects of learning within a single patient's journey.

The MDT Review will explore aspects of work within the Trust, focusing on work as done verses work as imagined or prescribed. This will utilise the patient safety incident as an index case, however, will focus on the work completed more widely than within this specific case to draw broader learning.

Patient Safety Incident Investigation

PSIIs will be a further option from the Patient Safety Response Meeting. PSIIs will be completed for all:

- Never Events,
- Deaths thought more likely than not due to problems in care,
- Deaths of patients detained under the MHA / MCA where death is linked to gaps in care,
- Incidents in NHS screening programmes that risk the effectiveness or public confidence in delivery of the programme,

Other incidents will be investigated via PSII where the Patient Safety Response Meeting considers the potential learning to be of a significant level and complexity to require an extensive investigation to allow the required quality improvement activities.

PSIIs will be led by the Divisional Clinical Governance Team and supported by expert advisors as required from Clinical and/or Operational teams. The Investigation leads will all be educated in the SEIPS methodology and attend networking sessions within the Trust to provide peer supervision and learning.

The Trust will liaise with those effected by Patient Safety Incidents and jointly consider the level of involvement those individuals would like to have in the investigation process. This consideration will be led by the Engagement Lead.

The Trust will also identify a Patient Safety Partner to support each PSII. The PSP role in each investigation will consider the level of expertise of the PSP and the capacity within their voluntary role. All PSPs will be supported to have equal input into the learning and areas for improvement identified during the PSII process.

- **Our patient safety incident response plan**

  Our plan sets out how Wirral University Teaching Hospital intends to respond to patient safety incidents over a period of 12 to 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 and the needs of those affected, as well as the plan.

- **Reviewing our patient safety incident response policy and plan**

  Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

  Updated plans will be published on our website, replacing the previous version.
  A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

3.6 Responding to patient safety incidents

- **Patient safety incident reporting arrangements**

All Patient Safety Incidents will be reported locally within the Team that identified the incident. This will occur as timely as practicable following identification of the incident and in all cases by the end of the next working day.

All Patient Safety Incidents will initially be reviewed by the identified Manager for the location that the incident was reported in. This initial managerial review will ensure that the information reported within the incident form is accurate and complete. Focus will be given to ensure:

- Accurate description of the incident,
- Patient and Staff identifiable information is only included in the appropriate sections of the form,
- Accurate cause groups have been identified,
- Accurate harm level has been identified,
- Appropriate future risks score has been identified,
- All immediate actions taken are recorded,
- All incident fields have been completed.

Following managerial review any further investigation can be triggered. The manager can indicate the need for a Rapid Evaluation of Care locally or consider escalation to another team or department (including external organisations).

- **Patient safety incident response decision-making**

Initial trigger for a further investigation will most commonly be made and suggested via the Managerial Review process, however this can also be initiated by any Executive Director or senior manager.

The initial stage of any further investigation will be completed via a Rapid Evaluation of Care. Following Rapid Evaluation of Care further learning can be taken through a Thematic Review, Facilitated Reflective Session or PSII. If no errors or omissions in care are identified (or deemed to be incidental findings to be managed at a local level only) the Rapid Evaluation of Care will be reviewed by the Patient Safety Steering Group Chairs' meeting to agree closure.

All incidents that note a reoccurring incident type, or reoccurring error or omission in care, and align with the workplan for a patient safety steering group, will be included within the next thematic review of that area. The decision making for thematic reviews will be made at the Patient Safety Steering Group Chair's meeting chaired weekly by the Deputy Director of Quality Governance or the Deputy Medical Director.

Incidents that require an individual review will be escalated for discussion at the Patient Safety Incident Response Panel. This will include incidents that identify errors or omissions

in care that have not previously been understood and have further learning potential. The meeting will consider the most proportionate response.

After Action Reviews are most suited to consider the patients journey through the Trust and consider the specific factors that led to errors or omissions in care. These facilitated reflective sessions will benefit from close time proximity to the incident and involving those staff that were involved in the incident and leading the service at the time.

MDT Reviews are most suited to reviewing an element of practice, often between professional groups or teams. Also described as reviewing work as done against work as imagined or the policy / practice gap. These facilitated reflective sessions can be completed even if the specifics of the patient care cannot be recalled and reflection is based on current practice more generally. This approach is suited where an incident may have been identified several weeks or months after the event. This is also useful when the staff members involved in the incident are unable to support the current investigation. An alternative reason for choosing this investigation style will be when the panel believe the error or omission could be more widespread than the local team or department.

A PSII will be initiated as per the specific criteria described earlier in this policy but also for any incidents that the meeting considers the potential learning to be of a significant level and complexity to require an extensive investigation to allow the required quality improvement activities.

The Trust Lessons Learned Forum will review the outputs from all responses to consider emerging themes and trends. This review may lead to additional patient safety steering groups being recommended or current groups standing down. This intelligence will be reported through the Trust and contribute to the development of future Patient Safety Incident Response Plans.

All PSIIs will require final approval via the Trust Executive Medical Director and/or Chief Nurse.

- **Responding to cross-system incidents/issues**

All incidents recommended for external review, following initial managerial review, will be shared via the Governance Support Unit. The sharing of incidents will always be coordinated between patient safety to patient safety team across organisations. The Trust will work closely with the System NHS Partners and local ICB Teams to ensure clear sharing lines.

All incidents reported by partner organisations that require review within the Trust will be shared via the Governance Support Unit and added to the local incident management system. Managerial review will be completed by the relevant team within 5 working days and any additional reviews will be triggered as with internally reported incidents. Themes from externally reported incidents will be drawn out and considered both alongside and within the wider pool of incidents.

Where incident investigation beyond managerial review demonstrates overlap with another local provider, a joint investigation will be completed. The recommendation for response type

will be considered internally and then negotiated with the other organisation to agree a clear response route and Terms of Reference.

- **Timeframes for learning responses**

Managerial Review will be completed within 5 working days of an incident being reported.

Rapid Evaluation of Care reports will be completed within 5 working days of Managerial Review.

Facilitated Reflective Session Reports will be completed within 40 working days of the Rapid Evaluation of Care

PSIIs will see timescales agreed at the Patient Safety Incident Response Meeting with a maximum time period of up to 6 months. The time period agreed will include timescales for investigation, identification of areas for improvement and development of an action plan. All stages will be completed within the agreed timescale (maximum of 6 months).

- **Safety action development and monitoring improvement**

Through the investigation process areas for improvement will be defined. Following the areas for improvement, safety actions will be developed to address each of these. When developing the safety actions a quality improvement methodology will be utilised to ensure the actions are clearly defined, describe responsibilities and timescales, aligned to reportable outcome measures, and include a detailed assurance / monitoring process.

Safety Actions must be developed with the clinical and operational teams that will implement these actions to ensure ownership of the actions and outcomes.

- **Safety improvement plans**

Safety Improvement Plans will be developed within all of the Patient Safety Steering Groups. These improvement plans will be a key focus of the regular thematic reviews within these steering groups and explore the impact of improvement plans on subsequent incidents.

There will be a clear alignment between some safety actions falling out of individual patient safety responses and the overarching safety improvement plans, these plans will often lead to the outcome measurement and assurance processes that underpin safety actions.

Safety improvement plans will be considered by the Lessons Learned Forum both to receive progress and assurance regarding existing plans but also to recommend the need for future improvement plans following review of responses and individual safety actions.

3.7 Complaints and appeals

The Trust is focused on quality improvement and supporting those affected by patient safety incidents, therefore it is expected that all actions to support a proportionate and thorough

investigation following a patient safety event will be delivered. This process should be fully inclusive of the considerations for those affected by the incident, however where patients and or families / friends do not feel the response to the patient safety incident has been appropriate or that they have not been supported appropriately via the Engagement Lead process a right to raise a concern or complaint will remain.

All people affected by a patient safety incident who wish to raise a concern or complaint can do so via the Complaints and PALS Team wuth.patientexperience@nhs.net

4 References

NHS England (2022) Patient Safety Incident Response Framework and supporting guidance [online] Available at: NHS England » Patient Safety Incident Response Framework and supporting guidance

Equality Analysis

387

The Equality Analysis (EA) form should be completed in the following circumstances:

- **All new policies**
- **All policies subject to renewal**
- **Business cases submitted for approval to hospital management impacting on service users or staff**
- **Papers submitted to hospital management detailing service redesign/reviews impacting on service users or staff**
- **Papers submitted to Board of Directors for approval that have any impact on service users or staff**

Title	Patient safety incident response policy			
Policy Reference	387			
Lead Assessor	Catherine Cumberlidge			
Date Completed	19/09/2024			
What groups have you consulted with? Include details of involvement in the EA process	Staff in area concerned	☑	Staff side colleagues	☐
	Service users	☐	HR	☐
	Other	☐	Other	☐
	Please Give Details			
What is being assessed? Please provide a brief description and overview of the aims and objectives				
The purpose of this policy is to outline the principles that should be followed in line with the national Patient Safety Incident Response Framework, established in September 2023.				
Who will be affected (Staff, patients, wider community?)				
Staff, patients and wider community as PSIRF will involve patients, families and patient safety partners.				

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your proposal/document has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed overleaf.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis. For further support with this, please refer to the Library and Knowledge Service accessible via the Trust's intranet site or switchboard.

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Positive: • Advance equality of opportunity • Foster good relations between different groups • Address explicit needs of equality target groups	**Negative:** • Unlawful discrimination, harassment and victimisation • Failure to address explicit needs of equality target groups	**Neutral:** • It is quite acceptable for the assessment to come out as Neutral impact • Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Group	**Any potential impact?** **Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (inc physical and mental impairments)	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Age	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Race (all ethnic groups)	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Religion or belief	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Sexual Orientation	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents

Pregnancy & Maternity	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Gender	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Gender Re-assignment	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Human Rights	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents
Other e.g. Carers	Positive	PSIRF will provide opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

In all cases - you should submit this document with your paper and / or policy in accordance with the governance structure with copies to wih-tr.EqualityWUTH@nhs.net for monitoring purposes.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

Who and how have you engaged to gather evidence to complete your full analysis? (List)	
Name & Job Title	**Name & Job Title**
What are the main outcomes of your engagement activity?	
What is your overall analysis based on your engagement activity?	

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the risk register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Following completion of the full analysis you should submit this document with your paper and or policy in accordance with the governance structure.

You should also send a copy of this document to wih.tr.equalityWUTH@nhs.net for monitoring purposes.

Consultation, Communication, and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis			This document is embedded within the Policy template
Policy Author Checklist			Checked for workforce / development, medicines, finance, or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Current Version Development	Patient Safety Quality Board Integrated Care Board		
Trust Staff Consultation via Intranet	30/10/2024 – 13/11/2024		

Date notice posted in the News Bulletin.		**Date notice posted on the intranet**	10/12/2024

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
Trust wide communications to raise awareness of PSIRF and this policy.	The GSU via Trust Communications
Presentation at Chief Nurse Check In	Safety Management Lead
Dissemination to Consultant body	Deputy Medical Director

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Aug 2023	1	Leigh McNeill	
May 2024	2	Leigh McNeill	Amendment to REC Process to include Multi- REC cases
DEC 2024	3	Catherine Cumberlidge	Amendment to REC Process to more proportionate response to falls, pressure ulcers and IPC incidents.

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Timeliness of Patient Safety Responses: • Managerial Review - 5 working days • Rapid Evaluation of Care (REC) - 5 working days. • Facilitated Reflective Session (FRS) Reports – 40 working days • PSIIs – (individual timescales) maximum 6 months	95% completed in timescale	Captured in Intelligence Report	Quality Committee (following discussion at PSQB)	Quarterly	Deputy Director of Quality Governance
Training of Response Leads • PSII Leads having undergone 2 day HSIB training • FRS Leads having undergone in house training • REC Leads having undergone in house training	100% compliance	Captured in Intelligence Report	Quality Committee (following discussion at PSQB)	Quarterly	Deputy Director of Quality Governance
Engagement Lead allocation for all PS Responses	100% compliance	Captured in Intelligence Report	Quality Committee (following discussion at PSQB)	Quarterly	Deputy Director of Quality Governance

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Governance Support Unit	PSQB	Quarterly

Safety of Patients and Public

Confirm the content of this policy does **not** risk the safety of patients or the public if it is uploaded to the public facing website	X
*If the content **does** affect the safety of patients or the public* if it is uploaded to the public facing website *please contact the Policy Coordinator or Risk Management Team for advice*	