Equality Impact Assessment
Stage 2

An Equality Impact Assessment (EIA) provides a framework for assessing if there are potential positive or negative impacts on some or all protected characteristics, as defined under the Equality Act 2010, in the development of services/strategies/policies.

An effective EIA:

- Demonstrates "due regard" for the Public Sector Equality Duty
- References evidence in the form of data and engagement with stakeholders
- Identifies mitigating actions to minimise any negative impacts

Once completed, this EIA should be sent to the Trust's ED&I Team for review: inclusion.workforce@nwas.nhs.uk.

Note: the Stage 2 EIA is to normally be completed following a recommendation based on the EIA Stage 1 Screening Tool and is intended (mostly) for major or complex strategies, projects/programmes or decisions which may significantly change or introduce a service or working practice. For all other programmes of work including policies and procedures, a fully completed Screening Tool may be sufficient. Please consult the ED&I Team for advice.

Name of the strategy/project/service development proposal being assessed:	Patient Safety Incident Response Framework		
EIA lead/author:	Daniel Redfern		
Date completed:	24/05/2023		
Date reviewed:	25/09/2023		
Version:	1		
Have you completed a Stage 1 EIA Screening Tool?	~~**Yes**~~	**No**	If so, attach PDF here:

Version history:			
Date	**Version**	**Author**	**Summary of changes / notes**
24/05/2023	1.0	D Redfern	Completed initial draft
14/06/2023	2.0	D Redfern	Final version
Approved by: PSIRF Project Board			**Date:** 24/07/2023

1. Overview

1.1. Provide brief outline of the project this EIA relates to

The aim of the Patient Safety Incident Response Framework (PSIRF) is to complement the aims of the National Patient Safety Strategy to support the creation of a system which delivers effective and sustainable change and improvement following patient safety events to prevent harm and deliver the safest possible patient care.

The PSIRF has been tested with a cohort of early adopters across a wide range of NHS provider types. The learning and insights gathered were collated and evaluated and used to inform the final PSIRF version, that was rolled out in August 2022 to replace the existing Serious Incident Framework (SIF), 2015.

Findings have suggested that those affected by incidents are not appropriately supported or involved in the investigation process; the quality of investigation reports is generally poor; and improvements to prevent the recurrence of harm are not effectively implemented.

This PSIRF is designed to embed a new approach to incident management which re-focusses systems, processes and behaviours to ensure responses deliver effective and sustainable reduction in risk rather than simply applying reactive processes that do not lead to change. It supports a systematic, compassionate and proficient response to patient safety events, anchored in the principles of openness, fair and equitable accountability, learning and continuous improvement.

There is some evidence that Black, Asian and Minority Ethnic (BAME) and other minority groups (Learning Disabilities, Mental Health, Elderly and Prison Populations), both in terms of staff and patients, can be disproportionality involved in the Serious Incident reporting process, and often have a more unpleasant experience.

Under PSIRF, providers are required to produce a Patient Safety Incident Response Plan (PSIR Plan). During the development of the plan, consideration for an Equalities and Health Inequalities Assessment for their own local system in terms of Patient Safety Incident Response and determine if they would benefit from a proactive approach towards addressing any inequalities.

The PSIRF will be implemented trust-wide across all front-line services; there are occasions when PSIRF will cross other service lines that could impact the safety of patients such as events with significant learning or those which would have such an impact if proactive measures were not undertaken.

A communications plan has been developed in conjunction with the trust communications team and shared with internal stakeholders.

NHS England mandates national training requirements for PSIRF which NWAS has invested in and currently undertaking. Ongoing training and development needs will continue to be addressed as they arise.

The PSIRF mandates various learning responses which are considered and proportionate to the needs of the event, staff will be required to undertake training and awareness sessions in order to facilitate learning responses in each service line.

1.2. Is this a new project or is this about reviewing/changing/amending something already in place?

Introducing a new project/strategy/service

1.3. If the project relates to reviewing/changing/amending current provision, please summarise the current provision, and describe the prospective changes being proposed.

As above – introducing a new system of managing patient safety incident responses.

1.4. Which stakeholders are likely to be impacted/affected as a result of the proposal(s)?
(please mark all that apply)

Stakeholder	Impacted	Groups
Patient / Service users / Citizens	☒	All patients and carers/families will be affected to the extent that they experience healthcare and are therefore potentially at risk of harm and so could be directly impacted by the PSIRF. In general, this impact should be positive given the PSIRF is focussed on improving safety and emphasises the importance of patient and family engagement and involvement in the management of incidents. There is increased potential for PSIR Plans and any associated EHI assessments to facilitate a positive impact on the experience of being involved in patient safety events for minority groups that deliver healthcare. The PSIRF should improve the potential for constructive learning. The approach to patient safety events proposed in the PSIRF means that trusts will have the opportunity to prioritise the responses to incidents that previously did not meet the definition of a Serious Incident, if there is potential for learning. This may make it easier to address concerns specific to patients from minority cultural and language backgrounds, and patients with disabilities if for example these are highlighted as priorities in the PSIR Plan. The PSIRF emphasises the need for improved transparency and support for those affected. Therefore, patients who have experienced an event and their families and carers should feel supported by the trust and feel that their concerns are being addressed, as well as being more involved with the process than previously. A section in the PSIRF is dedicated to this approach and has outlined several resources that can be employed.

		Patients/service users will be encouraged to report patient safety risks or events and given mechanisms for how to do so.
Carers	☐	
Staff	☒	Staff who manage events will be encouraged to adopt a different approach to responding to patient safety incidents known as “learning responses” than that which is currently seen under the SIF. Although the SIF never intended to focus on accountability and blame, local system approaches and mission creep from both internal and external organisations have resulted in these processes being associated with it. (For example, the Care Quality Commission (CQC) in some cases use number of Serious Incidents reported as a measure of performance, this will not be a useful measure under the PSIRF). The PSIRF clarifies that the focus should be on determining what the appropriate response to a patient safety event is and focussing the process on identifying what happened and why so that action can be taken to prevent or reduce the likelihood of it happening again. This includes avoiding making judgements relating to the incident’s avoidability, preventability, liability, predictability etc. Patient Safety Incidence Response should not be used as a performance management tool. Correspondingly, staff who are involved in an event should expect to be treated fairly and consistently during learning response processes, and in a way consistent with NHS Improvement’s just culture guide. Taking a broader system or theme-based approach to event review should have a particularly positive effect on staff groups that have traditionally faced disproportionate disciplinary actions, (e.g., BAME groups and other groups with protected characteristics). Staff involved in carrying out patient safety learning responses should be aware of the current biases in the system and proactively apply just culture and being open principles to address these. Staff at all levels will also be encouraged and given mechanisms to speak up about patient safety concerns or opportunities for improvement. For this to work effectively organisations, should be aware of and actively work toward a patient safety culture as described in the Patient Safety Strategy July 2019.
Partner organisations	☒	It is hoped that the number of inappropriate referrals that professional bodies such as the Health Care and Professionals Council (HCPC), General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) receive from trusts via the PSIRF will likely fall as the focus will be on learning and improvement and not individual blame. However effective alternative

		governance routes are in place that will continue to identify and manage poor performance. The CQC will apply the guidance provided in the PSIRF to assess the strength of an organisation's and/or systems approach and processes for preparing for and responding to patient safety events. The refocused approach to "learning response" will impact the nature of the reports received by the national patient safety team, and their response. Other organisations who may rely on or benefit from the quality of or information contained in trusts' investigations will also be affected. Continuous work is ongoing to work with all those affected throughout the transitional period and once fully implemented.
Other *(please specify)*	☐	

2. Evidence: data and engagement

2.1. How will/have you engaged stakeholders for the purposes of gathering evidence and/or testing the proposals?
Think about groups impacted internally and externally, engagement with Patient and Public Panel, Staff Networks, Trade Unions etc.

2.2. What data/information are you using to inform this assessment?
Think about this from a workforce and patient perspective, depending on which groups are likely to be impacted. List the main sources of data, research and other evidence reviewed to determine impact on each equality group applicable for this proposal. This may include national research, surveys, reports, population data, workforce data, complaints data, research interviews, feedback from focus groups, pilot activity evaluations or other equality analyses.

Protected characteristic / Equality group	Evidence / Information
Age *Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.*	Older people (e.g., 65 plus) are proportionally more affected by patient safety events than others due to the volume of healthcare they receive and the complexity of their needs.
Disability *This can include attitudinal, physical and social barriers as well as mental health, learning difficulties, long-term conditions, physical impairment and sensory impairments*	There is evidence that people with learning disabilities may be more at risk of patient safety events in NHS settings due to their vulnerable status. The PSIRF is designed to improve the way that organisations learn from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with learning disabilities.

	The more flexible approaches to prioritising learning responses given in the PSIRF may make it easier to address concerns specific to patients with learning disabilities, as there is the opportunity to learn from events that previously did not meet the definition of a Serious Incident. When developing their PSIR Plans organisations do not have to take a solely 'data driven' approach to their priorities, they could collectively decide that they will proactively respond to patient safety incidences in an area where the lived experience of a group is an area of concern. The PSIRF is designed to work seamlessly with the Learning from Deaths guidance, which specifies that acute, community and mental health trusts are required to review deaths of patients with learning disabilities, and that ambulance trusts must signpost these deaths to LeDeR to lead the review. Routinely reviewing these deaths allows problems in care to be identified and addressed. Wherever there is reason to believe that the death of a person with learning disabilities could have been contributed to by problems in care, the Learning from Deaths policy and the PSIRF require that death to be fully investigated. In this way problems with the care of those with learning disabilities are prioritised for learning, and future care should be improved. There is no current data within NWAS to identify if those with any physical disabilities are more likely to be involved in a patient safety incident/event. As part of the new framework and involvement with those affected (i.e., staff and their families) this data will start to be captured.
Gender reassignment (including transgender) *Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment*	There is a lack of evidence to suggest that an individual's trans status affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response. The move to the PSIRF, plus improvements in wider incident data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist. NWAS promotes and encourages treatment of all patients in a non-prejudice and person-centred way.
Marriage and civil partnership *This can include working arrangements, part-time working, and caring responsibilities.*	This protected characteristic is not applicable.
Pregnancy and maternity *This can include working arrangements, part-time working and caring responsibilities.*	MBRRACE-UK's 2018 report found that approximately 10 women per 100,000 die during pregnancy or up to six weeks after childbirth or the end of pregnancy, and there are certain risk factors which increase the likelihood of death. Women with multiple health problems or other vulnerabilities, Black and Asian women, older women and

	overweight or obese women all have a higher risk of dying in pregnancy. Where adverse outcomes in pregnancy and childcare occur, it is important that the care provided is examined to understand if there were any problems with the safety of the care provided. The Healthcare Safety Investigation Branch (HSIB) is a national body designed to improve safety by independently investigating patient safety concerns in the NHS. The PSIRF states that maternity incidents that fulfil the 'Each Baby Counts Criteria must be reported to HSIB for a national, independently led investigation. This includes all maternal and neonatal deaths, still births and neonatal hypoxic ischaemia.
Race *This can include information on different ethnic groups, nationalities, cultures and language barriers and resident status (migrants, asylum seekers).*	In relation to the treatment of staff following an event, the PSIRF emphasises the need to be conscious of the risk of bias and discrimination. Guidance states that organisations must ensure that staff involved in making decisions about referrals to other bodies undertake unconscious bias training and that the protected characteristics of staff referred to other bodies are recorded so that analysis of this data can be undertaken, and any patterns can be reviewed and addressed, and that procedures are consistently reviewed, and steps taken to understand and resolve inequality and potential unfair treatment. The PSIRF should have a particularly positive effect on staff groups that have traditionally faced disproportionate disciplinary actions and referrals for fitness to practice tests, such as staff from Black, Asian and other minority ethnic backgrounds and staff who trained overseas. The more flexible and proactive approaches to investigation given in the PSIRF may make it easier to address concerns specific to patients from minority cultural and language backgrounds, as there is the opportunity to investigate events that previously did not meet the definition of a Serious Incident. When developing our PSIR Plan, we may decide collectively that they will proactively review patient safety incidences in an area that highlights an area of concern, in this case for example, related to race. We have considered antidotally feedback in relation to language line and similar technologies for translation, this data is restricted due to lack of information currently available. The move to the PSIRF, plus improvements in wider data collection mechanisms, will allow more data to

	be gathered in this area and so determine if any inequalities exist.
Religion or belief *Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.*	There is a lack of evidence to suggest that religion or belief affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response. The move to the PSIRF, plus improvements in wider data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist.
Gender *Consider and detail evidence on men and women. This could include access to services and employment.*	There is a lack of evidence to suggest that gender affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response to the incident. The move to the PSIRF, plus improvements in wider data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist.
Sexual orientation *Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*	There is a lack of evidence to suggest that sexual orientation affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response. The move to the PSIRF, plus improvements in wider incident data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist.
Carers *Consider and detail evidence on part-time working, shift patterns and general caring responsibilities.*	We don't hold any evidence around engagement with carers as part of current practices in managing and reviewing events. The move to the PSIRF, plus improvements in wider incident data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist alongside their engagement.
Inclusion health groups *Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality and income.*	Broadly all health inclusion groups should benefit from better learning from patient safety events, leading to a reduction and improved standards of healthcare. All inclusion groups should benefit from patient safety leads and investigators who understand and apply the proactive measures to address health inequalities outlined in this document. An assessment will be made by individual teams, should a patient safety event occur on the necessity of collating data on any other specific inclusion groups (i.e., sex workers/homeless/drug and alcohol dependency).
Human Rights Act 1998 *Consider and detail evidence relating the Articles set out in the Human Rights Act (if applicable).*	

3. Assessment of the impact on equality groups (protected characteristics)

3.1. Taking into account the evidence gathered (as detailed in section 2), assess whether the project has a positive, negative or neutral impact on particular equality groups.

- A positive impact means promoting equal opportunities, reducing inequalities, improving access or improving relations between equality groups.
- A negative impact means that an equality group(s) could be disproportionately disadvantaged, discriminated against indirectly or directly or there may be a negative effect on relations between equality groups.
- A neutral impact means that it has no effect currently on the equality group(s)

Equality groups	Positive Impact	Negative Impact	Neutral Impact	Don't Know	Please provide a rationale for your answer
Age	☒	☐	☐	☐	The PSIRF is designed to improve the way that organisations learn from patient safety events and so should enhance understanding and improvement of safety thereby positively impacting on older people.
Disability	☒	☐	☐	☐	The more flexible approaches to prioritising learning responses given in the PSIRF may make it easier to address concerns specific to patients with learning disabilities, as there is the opportunity to learn from events that previously did not meet the definition of a Serious Incident.
Gender Reassignment	☒	☐	☐	☐	There is a lack of evidence to suggest that these protected characteristics affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response. NWAS promotes and encourages treatment of all patients in a non-prejudice and person-centred way.
Marriage and civil partnership	☐	☐	☒	☐	
Pregnancy and maternity	☒	☐	☐	☐	The PSIRF states that maternity incidents that fulfil the must be reported for a national, independently led investigation. This includes all maternal and neonatal deaths, still births and neonatal hypoxic ischaemia.
Race	☒	☐	☐	☐	The PSIRF should have a particularly positive effect on staff groups that have traditionally faced disproportionate disciplinary actions and referrals for fitness to practice tests, such as staff from Black, Asian and other minority ethnic backgrounds and staff who trained overseas. The more flexible and proactive approaches to investigation given in the PSIRF may make it easier to address concerns specific to patients from minority cultural and language backgrounds, as there is the opportunity to investigate events that previously did not meet the definition of a Serious Incident.
Religion or belief	☒	☐	☐	☐	There is a lack of evidence to suggest that these protected characteristics affects the likelihood of a person to experience a patient safety event or affects their experience of involvement in the response.
Gender	☒	☐	☐	☐	
Sexual Orientation	☒	☐	☐	☐	

Equality groups	Positive Impact	Negative Impact	Neutral Impact	Don't Know	Please provide a rationale for your answer
					NWAS promotes and encourages treatment of all patients in a non-prejudice and person-centred way.
Carers	☐	☐	☒	☐	The move to the PSIRF, plus improvements in wider incident data collection mechanisms, will allow more data to be gathered in this area and so determine if any inequalities exist alongside their engagement.
Inclusion health groups	☒	☐	☐	☐	
Human Rights	☒	☐	☐	☐	Supports Article 3 - Freedom from torture and inhuman or degrading treatment [which includes serious physical or psychological abuse in a health or care setting]

Carers and socially deprived communities are not protected characteristics as set out in the Equality Act 2010, but are health inequality groups which are priority groups for Cheshire and Merseyside to improve health outcomes for.

3.2. For any equality groups who are likely to experience negative or adverse impacts, what actions are you planning to take to mitigate and minimise the effects?

Equality group	Action	Lead	Timescales

Action	Health Inequality	By when	By whom
National Level			
Annual refresh of the national document with inclusive groups representation to update and refine recommendations considering emerging evidence.	All	Annually	National Patient Safety Team
Identify the availability of measures to ascertain if EHI have improved in the areas outlined in this document.	All	End of early adopter programme	National Patient Safety Team
Local system level			
Consider opportunities to align PSIR Plans to emerging strategies to tackle inequalities	All	Annual refresh of PSRIP	Patient Safety Team

Ensure adherence to national priority investigation criteria including those in relation to patient with MH issues or learning disabilities and incidents involving maternity care.		Ongoing	Patient Safety Team
Recruitment of Learning Response Leads/Engagement Leads should be selected on criteria that includes inclusive attitudes and behaviours.	All	Recruitment stage	Recruiting Manager
Senior Patient Safety leaders/oversight roles should undergo unconscious bias training	All	Ongoing	Relevant Leaders
Collection of protected characteristic data following consent of those affected by patient safety events.	Disability/Gender/gender reassignment/Ethnicity/Sexual orientation	Ongoing	Engagement Leads
Further exploration to consider how to record data related to inclusion health groups/.	Inclusion health groups	Annually	Programme/Project Team

4. Monitor and review.

Th EIA should be reviewed periodically throughout the development the project to consider for example if any new evidence emergences or if the groups impacted have changed in away. Any reviews undertaken to monitor progress on the action plan, or to add any new information through further data gathering or engagement should be documented. Timescales for EIA review should be built into the project plan.