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Patient Safety Incident Response Framework (PSIRF) Policy

Originated by:	Clinical Compliance Lead
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Policy Statement

The Patient Safety Incident Response Framework (PSIRF) advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

What is this policy intended to achieve?	This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out St Elizabeth Hospice'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.
To whom does this policy apply?	This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across St Elizabeth Hospice. It applies to all care related staff.
Which locations does this policy apply to?	All locations.
Who should read this policy?	All care related staff
Definitions and Terminology	

Contents

Equality, Diversity & Inclusion

This document recognises and respects the right for all of the individuals we support, their families and carers, to be treated with honesty, privacy and dignity at all times and that there is equal access to services for all groups, particularly in relation to race, gender, age, religious belief, sexuality, sexual orientation and disability. This means all actions undertaken or recommended for the protection of adults at risk and all policies and procedures will be based on assessments of risks and needs. They will not draw on stereotypical assumptions about groups that will be discriminatory in outcome. In undertaking its work, the Hospice will be sensitive and responsive to individuals' differences and needs.

Background

The NHS PSIRF was launched in 2022, to be fully implemented by autumn 2023. It is a contractual requirement for the hospice and replaces the Serious Incident Framework 2015.

The hospice engaged with Suffolk and North East Essex ICB regarding its requirements for PSIRF Implementation. In view of the numbers of incidents reported annually, it was agreed a shorter concise incident response plan will be created alongside this policy (see appendix 2).

Aims and Objectives

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

Scope

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.

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf

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.

Our patient safety culture

The hospice is open and honest, when things go wrong with care. In this regard, the hospice will follow the requirements for Duty of Candour which applies to notifiable patient safety incidents (see Appendix 1). A notifiable patient safety incident is an incident which is unintended or unexpected and in the reasonable opinion of a healthcare professional, already has, or might result in death, or severe or moderate harm to the person receiving care. The requirements for Duty of Candour include a verbal

and written apology, providing an update on enquiries. For the other incidents the hospice will ensure it is open with patients and families about what has happened, irrespective of the seriousness of the incident.

There is a strong culture to report all concerns and incidents, including near misses. We benchmark incidents with other hospices and report concerns as needed to the Trustees, the Regional Controlled Drug Accountable Officer, the CQC, and commissioners for transparency and learning.

Patient surveys, complaints and incidents are reported through the Governance process which is Trustee led. We are active members of the LIN (Local Intelligence Network), ECCH (East Coast Community Healthcare) joint governance meetings and IES Alliance Quality group.

Incidents and Complaints are reported using Vantage software and managed by the Incident, Risk and Complaints Group.

There is an agreed audit programme monitored by the Quality Assurance and Improvement Group (QAIG).

There is a Whistleblowing policy and Freedom to Speak up Guardians are in place. The hospice uses an external organisation for staff surveys.

The hospice collaborates on service improvements at all levels in the ICB (Integrated Care Board). The Director of Care is the co-chair of the ICB Die Well Group and will use this group for collaborative feedback on patient safety related incidents as needed.

The hospice will use the NHS Just Culture guide to treat staff involved in a patient safety incident in a consistent constructive and fair way. We support a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong rather than fearing blame.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

"Families would benefit from understanding how the Just culture guide works. Often families call for accountability and think they are asking 'who' is responsible, but my experience is they really want to know 'what happened and why'. This would help them on their journey after the avoidable death of a loved one."

Joanne Hughes, NHS Improvement patient and public representative and founder of mothers instinct: https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

Patient safety partners

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety. We have a Hospice Engagement Group (HEG) who are actively involved in co-production.

To ensure that patient safety is maintained and improved, the hospice will review and discuss patient safety incidents at:

- The Incident, Risk and Complaints Group
- Medicines Management Group
- Safeguarding Group

- Staff meetings

The Care and Clinical Governance Committee receives a quarterly report on all care related incidents and complaints.

Together, with the wider hospice multidisciplinary team, we will undertake thematic reviews of incidents i.e. falls, drug incidents and pressure ulcers, in order to try to identify learning. This will include involving patients and their families in the process for their feedback.

An MDT approach will support teams to learn from patient safety incidents that have occurred.

Addressing health inequalities

St Elizabeth Hospice recognises that we have a role to play in helping to reduce inequalities in health in palliative care by improving access to services around the need of our local population in an inclusive way. Under the Equality Act (2010) we will assess for any disproportionate patient safety risks across the range of protected characteristics to ensure nobody is disadvantaged.

Reasonable adjustments tool to be used for individuals for example, if a person with learning disabilities can't read or see safety signs, this will outline what we will put in place to ensure this person is aware and remains safe.

We will have representation at LeDeR panel meetings (Learning Disabilities Mortality Reviews).

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.

St Elizabeth Hospice Co-production Framework

Definition

"A meeting of minds coming together to find a shared solution. The approach is built on the principle that those who use a service are best placed to help design it. It means aspiring to being equal partners and co-creators."
(Adapted with people in Suffolk in 2019, inspired by the National Coproduction Advisory Group, Think Local Act Personal)

Key principles

- Upholding the value of shared decision-making - 'Nothing about me, without me'
- Co-production engages groups of people in equal partnership at the earliest stages of service design, development and evaluation.
- People with 'lived experience' are often best placed to advise on what support and services will make a positive difference. This is known as Experience- based co-design.
- All contributions are equal. It is important to have diverse representation, from those who use/have used services and those who understand the wider community.

- Barriers to inclusive participation should be addressed e.g. accessibility, expenses, reasonable adjustments.
- All participants should be willing to explore and negotiate different ways forward. It is important to avoid pre-conceived outcomes.
- There are different levels of co-production. The level employed should be overtly recognised and identified during projects (see ladder below).
- Effective co-production takes time. Realistic pace and project timescales are essential.
- Evidencing 'We said, we did' is essential to ensure the value, time and resources involved are justified.

There are many opportunities for staff and volunteers to share views and any concerns, across the hospice, including staff surveys, 1-2-1s, team meetings and having availability of the senior managers and People and Culture team.

The hospice states in its complaints and service user feedback procedure that 'all feedback will be welcomed and encouraged. Those making a complaint will be supported and listened to, not disadvantaged and treated with courtesy and empathy'.

Duty of Candour

Duty of candour is required for notifiable patient safety incidents: that is those that are unintended or unexpected, have occurred during the provision of an activity the CQC regulate and in the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

Our values are:

- One Team, one community
- Learning never ends
- Compassion takes courage
- Every moment matters

Patient safety incident response planning

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. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

St Elizabeth Hospice will take a proportionate approach in its response to patient safety incidents to ensure that the focus is on maximising improvement. The details will be expanded on in our PSIRF plan.

For better understanding of issues and causal factors, we will engage with patients, families and carers using a system-based approach.

Examples of patient safety incidents which will be investigated are:

- Any incident involving a patient
- Pressure ulcers
- Medication incidents
- A near miss incident which has potential to cause injury or damage
- Acts of violence or aggression which may lead to patient harm

- Incorrect clinical procedures
- Ill health i.e. allergy

Where necessary, some incidents may require review or referral to another body or team, for example, Learning Disability Mortality Review Programme (LeDeR), Safeguarding.

A PSII (Patient Safety Incident Investigation) is required where an incident meets a national priority. These include incidents, such as Never Events and deaths thought more than likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation). A PSII is required to be logged on the Strategic Executive Information System (StEIS), which will be replaced by the Learning From Patient Safety Events System (LFPSE). The ICB will be notified when a PSII is commissioned and will log on the Hospice's behalf on LFPSE.

Resources and training to support patient safety incident response

The ICB Head of Patient Safety/Patient Safety Specialist will be the hospice contact if an incident is to be shared with the SNEE ICB.

The Incident, Risk and Complaints group will advise and monitor incident and complaints investigations.

Key individuals involved in PSIRF will have the following training:

	No of days Training
Patient, family and staff involvement in learning from patient safety incidents	1 day
A Systems Approach to Learning from Patient Safety Incidents- Oversight Training	1 day
Systems approach to Patient Safety Incident Investigations	2 days

Further Actions:

- Review of all relevant to PSIRF policies
- Introduction and raising awareness of PSIRF across the hospice
- Further training to be identified for investigators

Our patient safety incident response plan

Our plan sets out how St Elizabeth Hospice 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. We will share draft plans with system partners as needed and the ICB.

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.

Responding to patient safety incidents

Patient safety incident reporting arrangements

A PSII is required when an incident meets the national criteria or for any local priorities where the agreed response is a PSII as set out in the incident response plan. A PSII may also be commissioned for any unexpected incidents of significant harm. The Director of Care will be required to inform the ICB Head of Patient Safety / Patient Safety Specialist so that the incident can be raised on St. Elizabeth Hospice's behalf on Strategic Executive Information System (StEIS), which will be replaced by the Learning From Patient Safety Events System (LFPSE).

Patient safety incident response decision-making

St Elizabeth Hospice has set out a plan that outlines how the hospice will respond to incidents (please refer to PSIRF plan, Appendix 2). Where a significant incident is reported, for example, either a near miss which could have caused lasting harm or an incident of moderate or greater harm, this will be reviewed internally for a decision on the most proportionate response, following the Hospice Incident Response Plan. The St Elizabeth Hospice Director of Care will discuss any significant incidents with the ICB for sharing, support and advice regarding the most proportionate investigation response.

Responding to cross-system incidents / issues

On occasions, St Elizabeth Hospice may be required to meet with other partners to discuss and learn from an incident which may not necessarily be our incident investigation to lead on. However, the hospice may have played a part in that patient's journey and so we will be willing to have a cross system approach in order to achieve the best, co-ordinated learning outcome.

Timeframes for learning responses

If a PSII is required, we will aim to complete this within 1 - 3 months (no longer than 6 months). We will liaise with family on a regular basis including any changes to the timeframes of an investigation.

Safety improvement plans

Actions as a result of investigations from incidents and complaints are managed via "actions" using the Vantage software and monitored by the Incident, Risk and Complaints Group.

Actions from surveys, audits and other feedback are discussed and reviewed at the Quality Assurance and Improvement Group.

Themes and trends are escalated to the Trustees at the Care & Clinical Governance Committee and Governance & Oversight Committee.

The Board of Trustees, along with the Senior Leadership team have a Dashboard which includes staffing sickness, recruitment, patient activity as well as complaints and incidents, which helps build a wider picture.

Associated Policies and Procedures

- Adult Safeguarding and Prevent Policy
- Drug Incident policy and procedure
- Complaints policy
- Incidents, reporting, investigating and follow up policy and procedure
- Whistleblowing Policy
- Freedom to Speak Up Policy
- Governance Framework

Compliance with statutory Requirements:

Contractual requirement to implement the NHS PSIRF by autumn 2023.

Responsibilities/Accountabilities

Title	Accountability
Chief Executive Officer (CEO)	Has overall responsibility for ensuring implementation of this policy
Director of Care	Has responsibility within the hospice for clinical incidents and ensuring all patient safety incidents and near misses are managed, reported and recorded appropriately.
All Staff	Are responsible for reporting incidents and near misses as soon as is possible via Vantage and to co-operate in any incident investigation. Report any near miss incident that had the potential to cause significant injury to a person.

Staff Training Requirements

All new staff will require Vantage training as part of their Induction to the Hospice. A Vantage 'How to' manual is available on SharePoint.

Monitoring (Including Audit) and Frequency of Review

This policy shall be reviewed every three years.

Data Protection

Does this Policy require sign off from the Data Protection Officer?	No	
Does this Policy already have a Protection Impact Statement?	No	If Yes, attach link here
Does this Policy require a Data Protection Impact Statement?	No	Review date:
DPO approved: n/a		Date: n/a
DPO comments		

Appendix 1 – Duty of Candour

Introduction

What is duty of candour?
Duty of Candour is a law which came into force in 2014. It states that all healthcare providers who are CQC (Care Quality Commission) registered must be open and honest with patients and families when things go wrong.

What incidents relate to the duty of candour?
Duty of Candour applies where there has been a 'notifiable safety incident'. This means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

- The death of a service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
- Severe harm, moderate harm or prolonged psychological harm to the service user

Severe harm is when there is a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Moderate harm is harm that requires a moderate increase in treatment and significant, but not permanent, harm.

Prolonged psychological harm is psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Notifiable safety incidents
According to the Care Quality Commission (CQC), a 'notifiable safety incident' is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all 3 of the following criteria:

1. It must have been unintended or unexpected
2. It must have occurred during the provision of an activity we regulate
3. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

If any of these 3 criteria are not met, it is not a notifiable safety incident (but remember that the overarching duty of candour, to be open and transparent always applies).

You should interpret "unexpected or unintended" in relation to an incident which arises in the course of the regulated activity, not the outcome of the incident. "Regulated activity" means the care or treatment provided. "Outcome" means the harm that occurred or could have occurred. So, if the treatment or

care provided went as intended, and as expected, an incident may not qualify as a notifiable safety incident, even if harm occurred.

This does not mean that known complications or side effects of treatments are always disqualified from being notifiable safety incidents. In every case, the healthcare professionals involved must use their judgement to assess whether anything occurred during the provision of care or treatment that was unexpected or unintended.

Although these are the recommended times Duty of Candour applies, we will apply these principles whenever something goes wrong irrespective of the seriousness of the incident.

Process

Although the Hospice endeavours to prevent incidents from occurring, unfortunately there are times where incidents occur which are detrimental to patients in our care, and on those occasions:

1. An incident form will be completed (Refer to: Procedure for the Reporting, Investigation and Follow up of Incidents) and followed up accordingly.

2. An appropriate person, for example, the falls lead, tissue viability lead, medicines management lead or other appropriate person will be assigned as the incident manager (to investigate the incident) and agree the next steps and will take the lead from their team for the following actions:

   a) The patient and/or their family will be offered an apology and told what has happened.
   b) The patient and/or family will be provided with a full, true and accurate account of all the known facts.
   c) The incident manager will investigate and if the incident meets the criteria of a notifiable incident, the patient and/or family will be informed of any immediate actions taken to address the consequences of the incident and advised what else the Hospice intends to do.
   d) In the case of a notifiable incident, the patient and/or family will be offered and provided with reasonable support.
   e) Refer to Hospice Procedure for Statutory Notifications to CQC to ascertain if CQC reportable.

3. The Hospice will identify the cause(s) of the incident.

4. The Hospice will share its findings with the patient and/or family.

5. The hospice will allow the patient and/or family the opportunity to ask any questions.

6. The hospice will undertake further investigation and then write to the patient and/or family to confirm the information already provided to date, the outcome of the investigation and offer a further apology.

7. The hospice will offer a follow up meeting if required to discuss the outcome of the investigation.

Throughout this process the hospice will follow its Procedure for the Reporting, Investigation and Follow up of Incidents and other relevant requirements and procedures. Through investigation the hospice will identify and implement any changes and/or opportunities for learning to reduce risk of incidents/harm.

Useful links and Information

CQC REGULATION 20 DUTY OF CANDOUR (Page updated 2022)
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

DUTY OF CANDOUR (Updated 2020)
https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour

GMC 2015 (Updated 2024)
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong

NMC CODE: DUTY OF CANDOUR (Refreshed 2024)
https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour

Appendix 2 - St Elizabeth Hospice - Patient Safety Incident Response Plan

(Updated Dec 2025)

Patient Safety Incident Type	Required Response	Anticipated improvement Route
Incidents meeting a national priority such as Never Events & those meeting the Learning from Deaths criteria	PSII – as soon as possible after the patient safety incident is identified.	Led by the incident owner. Completed within 1 – 3 months from the start date. To be reviewed by IRCG (Incident, Risks & Complaints Group). ICB Head of Patient Safety to be informed.
Patient related incidents resulting in moderate or above harm (including near misses)	Initial swarm huddle – as soon as possible after the patient safety incident is identified. To review in governance meetings for appropriate proportionate response which could include PSII or AAR.	Led by the incident owner. Completed no later than one month from the start. Reviewed by IRCG. Involvement of patients / clients / relatives & staff in developing safety actions & improvement plans.
Pressure ulcers Category 3 and above	Initial swarm huddle or MDT discussion – as soon as possible after the patient safety incident is identified. To review in governance meetings for appropriate proportionate response which could include PSII or AAR.	Led by the tissue viability lead. Completed no later than one month from the start. Reviewed by IRCG. New Pressure ulcers Category 3 and above reported to CQC.
Drug / medication related incidents resulting in level 3 or above harm (including near misses)	AAR using elements of SEIPS. Use SEIPS to identify focus of investigation.	Led by the incident owner. Completed within 7 days from the start. Reviewed by MMG (Medicines Management Group) Involvement of patients / clients / relatives & staff in developing safety actions & improvement plans. All controlled drug incidents submitted to LIN.
Multiple incidents identified as need for further investigation i.e. Multiple near miss falls incidents / medication related incidents	AAR (after action review)	Led by the incident owners. Completed within 1 month of start. Reviewed by IRCG / MMG

		May involve multiple stakeholders including patient representatives.
Delayed or failed admission, discharge or transfer into or from the community	AAR (after action review) – as soon as possible after the incident identified	Led by IPU Ward Manager. Completed within 5 days from start. Reviewed by IRCG
IT / Information Governance (IG) incident resulting in data breach	AAR (after action review) – as soon as possible after the incident identified	Led by DPO (Data Protection Officer) Completed within 5 days of start. Reviewed by IRCG
Theme identified by IRCG as requiring further investigation	SEIPS	Learning from incident Response. Developing Safety Actions. Improvement plans.

After Action Review (AAR)

A structured approach for reflecting on the work of a group and identifying strengths & weaknesses and areas for improvement. 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. Can be used for any activity or event that has been particularly successful or unsuccessful and aims to capture learning from these tasks to avoid failure and promote success for the future.

Swarm huddle

Swarm based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff "swarm" to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce the risk.

MDT (multidisciplinary team) review

The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

PSII (Patient Safety Incident Investigation)

A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

SEIPS (System Engineering Initiative for Patient Safety)

SEIPS (System Engineering Initiative for Patient Safety (SEIPS) is a framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool (e.g. to guide how we learn and improve following a patient safety incident, to conduct a horizon scan, and to inform system design).

St Elizabeth Hospice Data Analysis

	No of incidents over period Mar 2024–30 Sep 2025	Average - Month	Average - year
Falls, slips and trips	141	7.8	94
Pressure Ulcers	230	12.7	153
General Incidents *(not drug or falls)*	150	8.3	100
Drugs	210	11.6	140
Safeguarding	16	0.8	10.6

In addition to the above incidents, St Elizabeth Hospice do receive complaints/concerns which are dealt with appropriately and according to the hospice complaints policy.

Plan to be reviewed end of 2027.

References:
NHS England's Patient Safety Incident Response Framework (PSIRF).

Equality Impact Assessment Initial Screening Tool

Document Reviewer(s):	Director of Care	**Date Assessment Completed:**	29/12/2025

Assessment of possible adverse impact against any minority group			
Could the document have a significant negative impact on equality in relation to each area below?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	**No**	
1. Age		X	
2. Sex		X	
3. Disability		X	
4. Race or Ethnicity?		X	
5. Religion and Belief?		X	
6. Sexual Orientation?		X	
7. Pregnancy and Maternity?		X	
8. Gender Reassignment?		X	
9. Marriage and Civil Partnership?		X	

- You need to ask yourself:
- Will the document create any problems or barriers to any community or group?
- Will any group be excluded because of this document?
- If the answer to either of these questions is yes, you must complete a full Equality Impact Assessment.

Assessment of positive impact			
Could the document have a significant positive impact by reducing inequalities that already exist?	**Response**		**If yes, please state why, and the evidence used in your assessment**
	Yes	**No**	
1. Promote equal opportunities		NO	Embedded within Safeguarding principles.
2. Eliminate discrimination		NO	Discrimination is abuse so is covered in the policy.
3. Eliminate harassment		NO	Harassment is abuse so is covered in the policy.
4. Promote positive attitudes towards disabled individuals		NO	Disabled people potentially have care and support needs which is covered in the policy and promoting their wellbeing. Recognises that disabled children are more vulnerable to abuse and

			therefore positive actions should be taken to reduce the risk of abuse.
5. Encourage participation by disabled individuals		NO	Refer to Equal Opportunities.
6. Consider more favourable treatment of disabled individuals		NO	Refer to the protective characteristics & advocacy.
7. Promote and protect human rights		NO	Refers to Human Rights legislation and that children have a human right to safety and protection.

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality?						
Positive	**Please rate (delete as applicable) the level of impact**					**Negative**
			NIL			
Is a full equality impact assessment required? No						