Mersey Care
NHS Foundation Trust

Community and Mental Health Services

**TRUST-WIDE NON-CLINICAL DOCUMENT**

# Quality Practice Alerts (QPAs) Standard Operating Procedure

| | |
|---|---|
| **Policy Number:** | **SA46** |
| **Scope of this Document:** | **All Staff** |
| **Recommending Committee:** | **Patient Safety Committee** |
| **Approving Committee:** | **Executive Committee** |
| **Date Ratified:** | **November 2018** |
| **Next Review Date (by):** | **November 2021** |
| **Version Number:** | **2018 – Version 2** |
| **Lead Executive Director:** | **Medical Director** |
| **Lead Author(s):** | **Director of Patient Safety** |

**TRUST-WIDE NON-CLINICAL DOCUMENT**

**2018 – Version 2**

***Striving for Perfect Care for the People We Serve***

**TRUST-WIDE NON-CLINICAL DOCUMENT**

# QPAs Standard Operating Procedure

## Further information about this document:

| | |
|---|---|
| Document name | **Quality Practice Alerts (QPAs) Standard Operating Procedure** |
| Document summary | This document provides a definition of QPAs; when and by whom they should be conducted and describes the process that should be used by the whole Trust in conducting, sharing and monitoring QPAs . |
| Author(s)<br><br>Contact(s) for further information about this document | **Steve Morgan**<br>**Director of Patient Safety**<br>Telephone: 0151 473 2874<br>Email: steve.morgan@merseycare.nhs.uk |
| Published by<br><br>Copies of this document are available from the Author(s) and via the trust's website | **Mersey Care NHS Foundation Trust**<br>**V7 Building**<br>**Kings Business Park**<br>**Prescot**<br>**Merseyside**<br>**L34 1PJ**<br>**Your Space Extranet:**<br>**http://nww.portal.merseycare.nhs.uk**<br>**Trust's Website www.merseycare.nhs.uk** |
| To be read in conjunction with | • Risk Management Policy (SA02A)<br>• Risk Management Strategy (SA02)<br>• Corporate Policy & Procedure For The Reporting, Management And Review Of Adverse Incidents (SA03)<br>• Policy and Procedure for the Management of Complaints and Concerns (SA06)<br>• Being Open Policy (SA13)<br>• Policy and Procedure for the Reporting Management and Investigation of Claims (SA05)<br>• Health and Safety and Wellbeing Policy (SA07)<br>• Policy for the Recognition, prevention and therapeutic management of Aggression and Violence (SD 18)<br>• Policy For Safeguarding Vulnerable Adults From Abuse (SD17)<br>• Procedure for the Systematic Approach to the Analysis and Learning from Incidents, Complaints and Claims (SA32)<br>• Policy and Procedure for Reviewing And Implementing The Recommendations of National Confidential Enquiries/ Inquiries (SA33)<br>• Clinical Audit Policy (**SA39)** |
| **This document can be made available in a range of alternative formats including various languages, large print and braille etc** | |
|  | |

## Version Control:

| | | |
|---|---|---|
| QPA SOP, Version 1 | Patient Safety Committee for consultation | October 2017 |
| QPA SOP, Version 1 | SOP reiterated by Policy Group | October 2017 |
| QPA SOP, Version 2 | Minor amendments to template | October 2018 |
| QPA SOP , Version 3 | Minor amendments to template | December 2019 |

## SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

### SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:
being alert to the possibility of child adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child adult; knowing how to deal with a disclosure or allegation of child/adult abuse; undertaking training as appropriate for their role and keeping themselves updated; being aware of and following the local policies and procedures they need to follow if they have a child adult concern; ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team; participating in multi-agency working to safeguard the child or adult (if appropriate to your role); ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation; ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

### EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

# Contents

## 1. PURPOSE AND RATIONALE

1.1 As part of managing the health, safety and welfare of everyone who the Trust interacts with Mersey Care NHS Foundation Trust is required to control risks and take action to prevent harm, and incidents from happening, improve best practices in clinical areas and ensure the safety of service users, staff and third parties.

## 2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 Quality Practice Alerts (QPA's) are the result of a systemic issue, generally affecting a service or the ability to deliver a high quality service and are aimed at increasing awareness of safety issues and improving safety and minimising the likelihood of re-occurring incidents.

2.2 The purpose of this guideline is to set out the Trust process for identifying and sharing QPA's and implementing, monitoring and reporting progress in relation to identified actions, thus ensuring continual improvement in the quality of services provided against Trust's guidelines, Polices and statutory requirements.

## 3. SCOPE

3.1 This guideline is a **Trust-wide** document and it applies equally to all members of staff, either permanent or temporary and to those working within, or for, the trust under contracted services.

## 4. DEFINITIONS

4.1 **Adverse Incident:** Any event or circumstance leading to unintended harm and/or suffering which results in admission to hospital, prolonged hospital stay, or significantly disability at discharge or death.

4.2 **Event:** Incident or situation, occurring in a particular place during a particular interval of time.

4.3 **Frequency**: A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time.

4.4 **Hazard**: A source of potential harm or a situation with the potential to cause loss.

4.5 **Impact (or consequence):** The outcome of an event, being a loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organization.

4.6 **Patient Safety Incident**: Any unintended or unexpected incident(s) that could have or did lead to harm of one or more persons receiving NHS funded healthcare.

4.7 **Likelihood:** A qualitative measure/description of probability or frequency. Any negative consequence, financial or otherwise.

4.8 **Near Miss**: A situation in which an event or omission, or a sequence of events or

omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to patient.

4.9 **Quality Practice Alerts (QPA):** Communication, normally related to safety, which must be distributed to appropriate personnel. Some alerts may require acknowledgment or actions to take place within a defined timescale.

4.10 **Quality Review Visit (QRV):** An annual programme of visits to all wards/community based teams, which takes place on site and involves observation in practice direct contact with ward/team staff, service users and carers if available and quality assessing clinical records and team procedures and communication.

4.11 **Risk:** An unplanned event, which should it occur it will have an adverse impact on the organisation's objectives. It is measured in terms of impact and likelihood.

4.12 **Risk Management**: The culture, processes and structures that are directed towards the effective management of potential opportunities and/or adverse effects.

4.13 **Risk Management System (RMS)**: Systematic application of management policies, procedures and practices to the tasks of establishing the context of risk and then, identifying, analysing, evaluation, treating monitoring and communicating risk.

## 5. DUTIES

5.1 **Executive Medical Director** – is the Board of Directors member with responsibility for QPAs who will keep the Board of Directors informed of major developments on related issues.

5.2 **Director of Patient Safety** – has overall responsibility for:

a) Leading and coordinating all aspects of QPA identification/ action evidencing and follow up with the Divisions.

b) Ratifying QPA's for local or Trust wide cascading.

c) Liaising with QPA authors and senior managers where the management of issues / risks have a wider impact and where identified actions were deemed inadequate.

5.3 **Head of Risk & Emergency Preparedness, Resilience and Response**

a) Supports the Director of Patient Safety and acts as a deputy when appropriate.

b) Liaise with Director of Patient Safety, Senior Managers and Adverse Incident / Risk Leads regarding risks deriving from events, incidents, clinical audits and QRVs and must be added on the risk register.

5.4 **Chief Operating Officers / Associate Medical Directors / Director of Operations/ Quality Leads**

a) Ensure that all QPA's related to their areas of responsibility are identified, assessed, recorded and reported, and that appropriate measures are in place to manage any risks/ issues and provide assurance on their effectiveness, through the relevant process and system.

b) Ensure that processes are in place for QPAs to be highlighted in local induction for new staff.

c) Ensure as a delegated responsibility that draft versions of QPAs are verified and forwarded within the specified timescale.

d) Responsible for having systems in place which will ensure that action plans are implemented within the timeframe and reported.

5.5 **All Senior Managers / Divisional Risk & Adverse Incidents Leads** –are responsible to:

a) Ensure that all QPA's related to their areas of responsibility are identified, assessed, recorded and reported, and that appropriate measures are in place to manage any risks/ issues and provide assurance on their effectiveness, through the relevant process and system.

b) Assess QPAs and (when needed) send feedback directly to the author of a QPA within the agreed timeframe.

c) Ensure QPA relevance to their areas is assessed by a multi-disciplinary team within the agreed timeframe.

d) Are responsible to create and review dissemination lists for their service and/ or directorate on a regular basis to ensure that cascading is targets the appropriate staff.

e) Ensure that all staff in their Team/ Division is aware of and operate within the present guidance.

f) Report on responses on all new QPAs at the Trust wide Patient Safety Committee and to the Chief Operating Officers of their area.

g) Identity gaps in the implementation of the procedure and report to the Chief Operating Officer.

h) Liaise with the Head of Risk and EPRR regarding risks deriving from events and incidents and must be added on the risk register.

5.6 **Deputy Director of Nursing and Quality**

a) Additionally to the above, the Deputy Director of Nursing and Quality is required to incorporate QPAs within the Quality Review Visits (QRVs) and

clinical audits undertaken by their team.

b) Share findings and recommendations with Director of Patient Safety.

5.7 **Modern Matrons / Clinical Team & Ward Managers**

a) Responsible for monitoring the adherence to the QPA process within their service on a daily basis.

b) They have responsibility for ensuring that any appropriate training associated with QPA process is undertaken by clinical staff within their service.

c) Are responsible for ensuring that all staff members are aware of new QPAs and that recommendations are followed.

5.8 **Allocated Patient Safety Team administrator**

a) Ensure that QPAs are ratified by the Director of Patient Safety within the agreed timeframe.

b) Share ratified QPAs with risk leads via the RMS.

c) Ensure that recorded actions are followed up and provide feedback to Director of Patient Safety and Divisions / Senior Managers.

d) Upload QPAs on SharePoint. http://sharepoint.merseycare.nhs.uk/sites/ClinicalGovernance/PatientSafety/QPA/QualityPracticeAlerts/Forms/AllItems1.aspx

e) Highlight any identification of trends and share with the Director of Patient Safety and the Patient Safety Committee.

5.9 **Responders** – are required to take responsibility for sharing the alert with other staff either via email or hard copy and discuss it's contents at the next available team meeting.

5.10 **Clinical Audit team –** are required to undertake annual audits to identify non conformity to the QPA processes outlined in the SOP. A report will be produced outlining the non conformity and any recommended corrective actions.

5.11 **All staff and contractors (including Locums, Temporary Staff and Bank Staff)** – are required to be familiar with the Trust's QPA sharing and evidencing system and take responsibility when conducting their duties in accordance with the principles laid out in Trust's policies and procedures.

5.12 **Groups & Committees**

**Patient Safety Committee**

5.12.1 The Patient Safety Committee is chaired by the Director of Patient Safety. Members have responsibility for monitoring the effectiveness of the implementation of the QPA guideline and adherence to national guidelines.

Each Division is represented by their Adverse Incident Lead. This Group will: -

a) Share learning and risk information and monitor the QPA actions of Divisions.
b) Disseminate relevant external inquiry information / reports
c) Monitor the adherence to the Trust's QPA guideline.

5.12.2 **Divisional Governance**

Each Division will manage and oversee QPA dissemination and learning stemming from them, at their existing weekly multi-disciplinary forum. This Group provides a vehicle to: -

a) Validate all recent QPAs.
b) Monitor team response and plan remedial action when it is deemed low/ inadequate.
c) Monitor the completion of actions.
d) Monitor adherence to the Trust's QPA guidance.

## 6. PROCESS

### 6.1 DEFINITION AND CONTENTS OF QPAs

6.1.1 Quality Practice Alerts (QPA's) are a fast, efficient and dynamic communication method that supports all Mersey Care staff to learn from: -

a) Adverse incidents, events and near misses.
b) Complaints and claims.
c) Clinical Audits and QRVs.
d) Investigations.
e) Risk registers.
f) Best practice identified from the above and from other local and national sources.

6.1.2 QPAs aim to warn and inform on current events, incidents or near miss events that require clinical staff's immediate reaction and awareness. They also aim to identify gaps in service operation/ delivery and to provide recommendations for resolution and best practice guidance.

### 6.2 CONDUCTING A QPA

6.2.1 Directors, Chief Operating Officers, Associate Medical Directors, Directors of Operations, Senior Managers and Divisional Risk & Adverse Incidents Leads are responsible for identifying issues and risks that raise the need for a QPA.

6.2.2 Using the template in **Appendix C** the author of a QPA must:

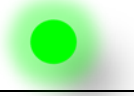
a) Title and date the document,
b) Define the level of alert.
c) Add a brief description of the issue(s) that lead to the alert.
d) Recommend actions to be taken by the appropriate staff, incorporating all relevant attachments when appropriate.
e) Ensure that divisional contact information regarding QPAs is on the template.
f) Sign the QPA.

6.2.3 **Title and date**

It is essential that the QPA's title is clear and relevant to the issue and actions described. This, along with the QPA reference (which will be added by the Patient Safety team administrator) will assist all staff to refer back to it in the future, if and when needed and will eliminate duplications. The correct date on the document will define whether deadlines are met in regards to the process and the actions recommended.

6.2.4 **Types of Alerts**

There are 2 types of QPAs and each of them defines the urgency of cascading the information and completing the actions. The table below describes the 2 alerts types and provides the appropriate explanation on how each of them could impact services.

| Type | Marking | QPA Impact of services | Explanation |
|---|---|---|---|
| **Type 1** | **Green**  | New information/ Identified Learning | QPAs of this Level aim to inform staff on lessons learnt from recent events and incidents. |
| **Type 2** | **Red**  | Warning<br>Urgent Situation<br>Rapid/ Immediate response | QPAs of this level need the immediate attention of all staff and actions and measures must be attended with urgency. |

6.2.5 **Description**

Authors of QPAs are strongly advised to include a brief description of the event(s) or incident(s) that lead to conducting one. They should include information on the effects of the event/ incident on services and identify gaps and areas of improvement.

6.2.6 **Recommendations**

Authors of the QPA must identify all actions that need to taken by the appropriate staff, incorporating all relevant attachments when appropriate.

6.2.7 Following Trust's best practice guidelines, actions recommended must be S.M.A.R.T. (Specific, Measurable, Achievable, Realistic and Time based). This will assist all staff to understand what it is required of them and equip them with the tools and available resources to complete the actions in a realistic and effective manner. It will also assist leads to follow up on recommendations.

6.2.8 **Divisional contact information regarding QPAs**

Divisional contact information regarding QPAs must be available to all staff. This enables dialog in all cases where additional information is required or concerns need to be raised**.** If there isn't one, Divisions are advised to create a generic email address, to which more than one person have access, to avoid single point of dependency.

6.2.9 **QPA signature**

It is essential that the author of the QPA includes their name and contact information within the document, as this will direct the appropriate staff to the right person when discussions arise prior to the ratification of a new QPA or when an existing QPA needs to be reviewed.

6.3 **REVIEWING EXISTING QPAs (Flowchart in Appendix A)**

6.3.1 All ratified QPAs are kept on SharePoint and all staff has access to view them.

6.3.2 All QPA authors, prior to conducting a QPA, are required to search the existing

database and define whether a QPA on their topic already exists.

6.3.3 In the event a similar QPA already exists, the author must determine if the existing QPA is still fit for purpose. Liaison with the author of the original QPA is highly recommended.

6.3.4 The revised QPA must be marked as such within the title and the Patient Safety administrator should be notified to make the appropriate changes on SharePoint.

6.3.5 When a QPA is reviewed and ratified, the Patient Safety administrator must refer to the database and mark the existing QPA as revised, including the new reference number. The old QPA will not be removed from the database and a message that the QPA has been revised will be highlighted to notify all staff referring to it.

6.3.6 A summary of the above can be viewed in the flowchart on the next page.

6.4 **QPA DISTRIBUTION & MAINTENANCE PROCESS (Flowchart in Appendix C)**

**Step 1 – Ratification**
(To be completed within 24 hours)

6.4.1 An initial draft version of the QPA to be conducted in the agreed format (template in Appendix C) and to be sent to the allocated Patient Safety Administrator who will polish the document.

6.4.2 The QPA document is ratified for Divisional or Trust wide cascading by the Director of Patient Safety.

6.4.3 The allocated Patient Safety Administrator will allocate a reference number to the alert and cascade to risk leads via the RMS.

6.5 **Step 2 – Identification of Relevance**
(This step will not take more than 7 days to be completed and **where a QPA is marked as urgent, Divisions have 48 hours).**

6.5.1 Divisions to discuss the alert at their following weekly governance/ multi-disciplinary meeting and identify:

a) Relevance of the alert to their different areas
b) Identify appropriate staff to respond to the alert
c) Identify staff that need to be informed about the alert
d) Review recommendations/ actions and amend as appropriate

6.5.2 Any queries regarding the QPA must be raised directly with the author.

6.5.3 Upon agreement, divisional risk leads will cascade the alert to the appropriate staff for action or for information via the RMS.

6.6 **Step 3 – Distribution and response**
(Recommendations will be underway within 7 days of receiving the alert).

6.6.1 Service Managers, to whom the QPA is relevant to, will receive an email

notification generated by the RMS stating that a new QPA has been distributed and that they are required to read, share with other staff and take action within the identified timeframe.

6.6.2 Each person who is identified as a responder is obligated to share the alert with other staff either via email or hard copy and discuss it's contents at the next available team meeting.

6.6.3 Each Ward or Department should have an identified area (display board) for sharing the QPA where they should display the information for at least 3 weeks. A red triangle will designate the QPA space on the board.

6.6.4 A central record of all the QPAs shared is kept on SharePoint. Each Ward or Department Manager is responsible for knowing where QPAs are retained, so that they can be accessed for future reference or training need.

6.6.5 Actions taken/ responses must be recorded on the RMS.

6.7 **Step 4 – Maintenance**

6.7.1 The allocated Patient Safety Administrator will update the QPA database on SharePoint.

6.7.2 Cross referencing and updating of issues will be undertaken when similar issues are being raised for dissemination via the QPA process. The appropriateness of the previous actions taken will be reviewed to enable the most valid changes to practices to be made.

## 7. FOLLOW UP - Summary table

<table>
<tr><th colspan="2">DIVISIONAL/ DIRECTORATES FOLLOW UP</th></tr>
<tr><th>DIVISIONS</th><th>PATIENT SAFETY COMMITTEE</th></tr>
<tr><td>• Staff to acknowledge QPA on system and commit to commence actioning recommendations within 7 days.<br><br>• Leads to ensure that actions are completed and recommendations are implemented within the recommended timeframe.<br><br>• Add to Division's monthly multiagency governance/ Board meeting agenda for discussion on:<br>- Follow up on team performance and compliance.<br>- Recommendations from Patient Safety Committee.<br><br>• Report to Patient Safety Committee on completed actions and actions due for completion.<br><br>• Collate information for CQC.</td><td>• Standing item on agenda for discussion on<br><br>- new QPA's<br><br>- Follow up on completed actions<br><br>• Review of process and suitability of systems.</td></tr>
<tr><th>PATIENT SAFETY TEAM</th><th>CLINICAL AUDIT & EFFECTIVENESS TEAM</th></tr>
<tr><td>• Monitor and report to Patient Safety Committee on:<br>- Number of QPAs that have invoked a formal response.<br><br>- Number of actions due for completion.<br><br>• Liaise with Clinical Audit and effectiveness team re audits and QRV results – Present findings at the patient safety committee.</td><td>• Incorporate QPAs in the clinical audit programme for each year. (Divisional audit teams are included in the process).<br><br>- Tailored audits according to needs<br><br>- Annual clinical audit at the end of each year.<br><br>• Provide information and recommendations deriving from QRVs.</td></tr>
</table>

## 8. CONSULTATION

The following Trust representatives have been consulted in the development of this standard operating procedure:

a) Director of Patient Safety.

b) Head of Risk and EPRR.

c) Deputy Director of Nursing and Quality.

d) Patient Safety Committee.

## 9. TRAINING AND SUPPORT

9.1 The training the Trust provides on Quality Practice Alerts process and system includes: -

a) Awareness raising sessions within Mandatory and Induction Training.

b) Specifically tailored training for Departments and Teams –developed on request or through concerns regarding the level of evidence reporting.

9.2 Training will be available as identified for managers to ensure sufficient knowledge and skill to handle QPAs on the RMS.

## 10. MONITORING

10.1 Characteristics of the Trust Quality Practice Alerts System and Process will be monitored and analysed where appropriate.

10.2 Monitored information includes:

a) Number of QPAs that have invoked a formal response.

b) Number of actions completed.

### 10.3 Audits

10.3.1 An Internal audit on QPA's will be planned, documented, undertaken and recorded at a minimum of once a year. Identified non conformity to the QPA procedures will be recorded within the audit report, and any required corrective actions implemented.

### 10.4 Management Review

10.4.1 One mechanism for maintaining and reviewing the QPA arrangements is through the annual management review, where performance, suitability, and the need for systemic changes are discussed.

10.4.2 This Review will include identification of opportunities for improvement and the need for changes.

10.4.3 The Reviews will be clearly documented and maintained in accordance with the Trust's governance arrangements.

10.4.4 The Director of Patient Safety will review the Trust's QPA's Management System annually, to ensure its on-going suitability, adequacy, and effectiveness.

**10.5 Nonconformity and Corrective Action**

In a situation where the QPA arrangements have not performed as expected, a nonconformity report must be raised to record the situation and subsequent improvement actions thereof.

**10.6 Continual Improvement**

Through the setting and monitoring of objectives, acting upon problems and outcomes of exercises and incidents, The Trust will endeavour to continually improve the effectiveness of its QPA arrangements.

**10.7 Lessons Learnt**

Lessons learnt from QPA monitoring are used to determine any amendments or inclusions required within service delivery areas. All lessons will be presented to the Patient Safety Committee and cascaded to the divisions via the Adverse Incidents/ Risk leads.

## 11. EQUALITY AND HUMAN RIGHTS ANALYSIS

| |
|---|
| **Title: Quality Practice Alerts Standard Operating Procedure** |
| **Area covered: TRUST-WIDE NON CLINICAL POLICY DOCUMENT** |

| |
|---|
| **What are the intended outcomes of this work?**<br>This document provides a definition of QPAs; when and by whom they should be conducted and describes the process that should be used by the whole Trust in conducting, sharing and monitoring QPAs . |
| **Who will be affected?**<br>**All staff** |

| **Evidence** |
|---|
| **What evidence have you considered?**<br>**The SOP** |
| **Disability inc. learning disability**<br>**No issues identified within discussions.** |
| **Sex**<br>**No issues identified within discussions.** |
| **Race No issues identified within discussions.** |
| **Age No issues identified within discussions.** |
| **Gender reassignment (including transgender)**<br>**No issues identified within discussions.** |
| **Sexual orientation No issues identified within discussions.** |
| **Religion or belief**<br>**No issues identified within discussions.** |
| **Pregnancy and maternity**<br>**No issues identified within discussions.** |
| **Carers**<br>**No issues identified within discussions.** |
| **Other identified groups**<br>**No issues identified within discussions.** |
| **Cross cutting No issues identified within discussions.** |

| **Human Rights** | **Is there an impact?**<br>**How this right could be protected?** |
|---|---|
| **This section must not be left blank. If the Article is not engaged then this must be stated.** | |
| **Right to life (Article 2)** | **No issues identified within discussions.** |
| **Right of freedom from inhuman and degrading treatment (Article 3)** | **No issues identified within discussions.** |
| **Right to liberty (Article 5)** | **No issues identified within discussions.** |

| | |
|---|---|
| **Right to a fair trial (Article 6)** | **No issues identified within discussions.** |
| **Right to private and family life (Article 8)** | **No issues identified within discussions.** |
| **Right of freedom of religion or belief (Article 9)** | **No issues identified within discussions.** |
| **Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)** | **No issues identified within discussions.** |
| **Right freedom from discrimination (Article 14)** | **No issues identified within discussions.** |

Engagement and involvement N/A

**Summary of Analysis**

**Eliminate discrimination, harassment and victimisation**
**No issues identified within discussions.**

**Advance equality of opportunity**
**No issues identified within discussions.**

**Promote good relations between groups**
**No issues identified within discussions.**

**What is the overall impact?**
**No impact on equalities detected within discussions.**

**Addressing the impact on equalities**
**No impact on equality groups.**

**Action planning for improvement**
**Not required.**

**For the record**
**Name of persons who carried out this assessment (Min of 3):**
**Steve Morgan**
**Burt Burtun**
**Christiana Vasiliou**

**Date assessment completed:**
**5 January 2018**

**Name of responsible Director: Medical Director**

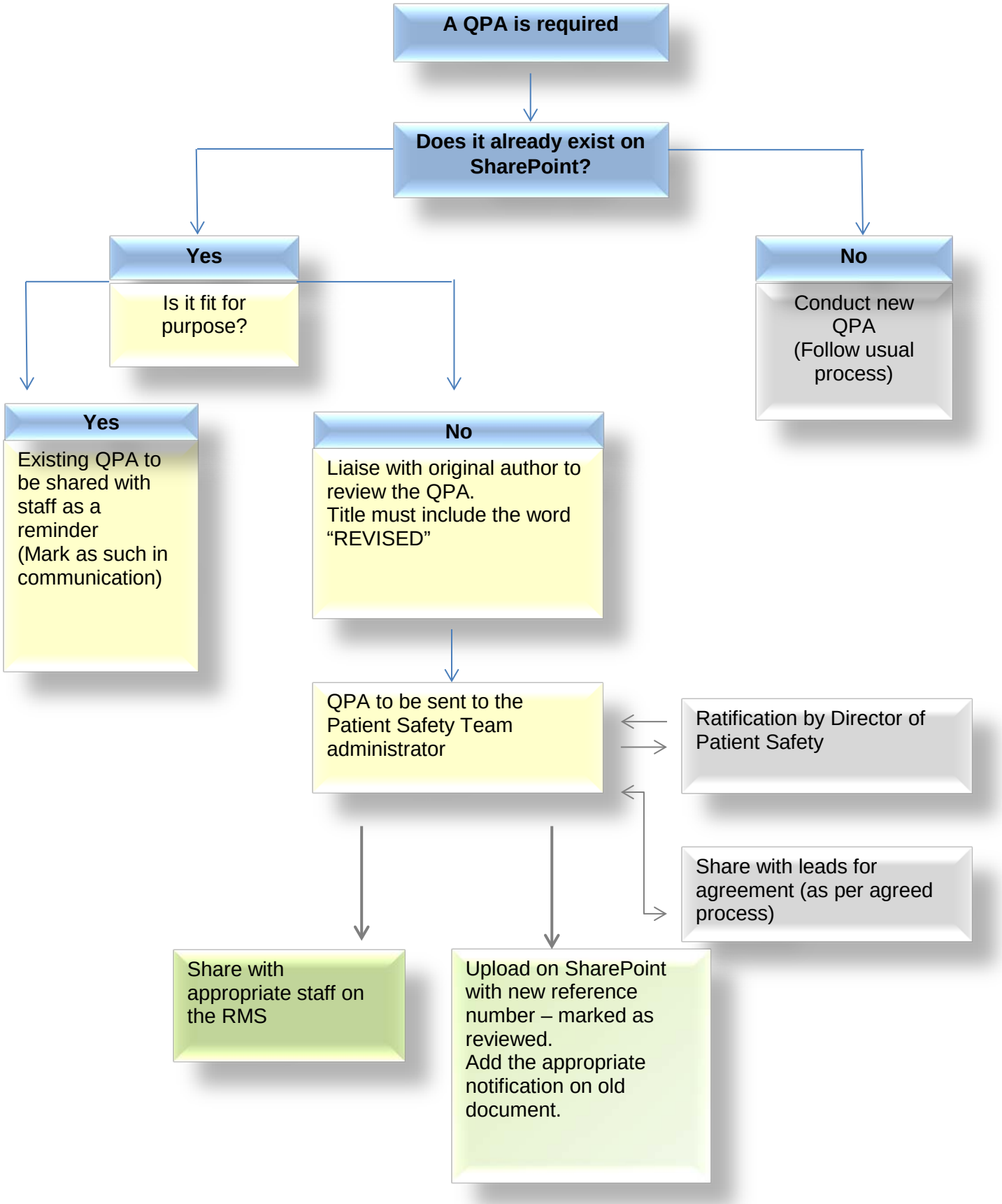
**Date assessment was signed:**

## Action plan template

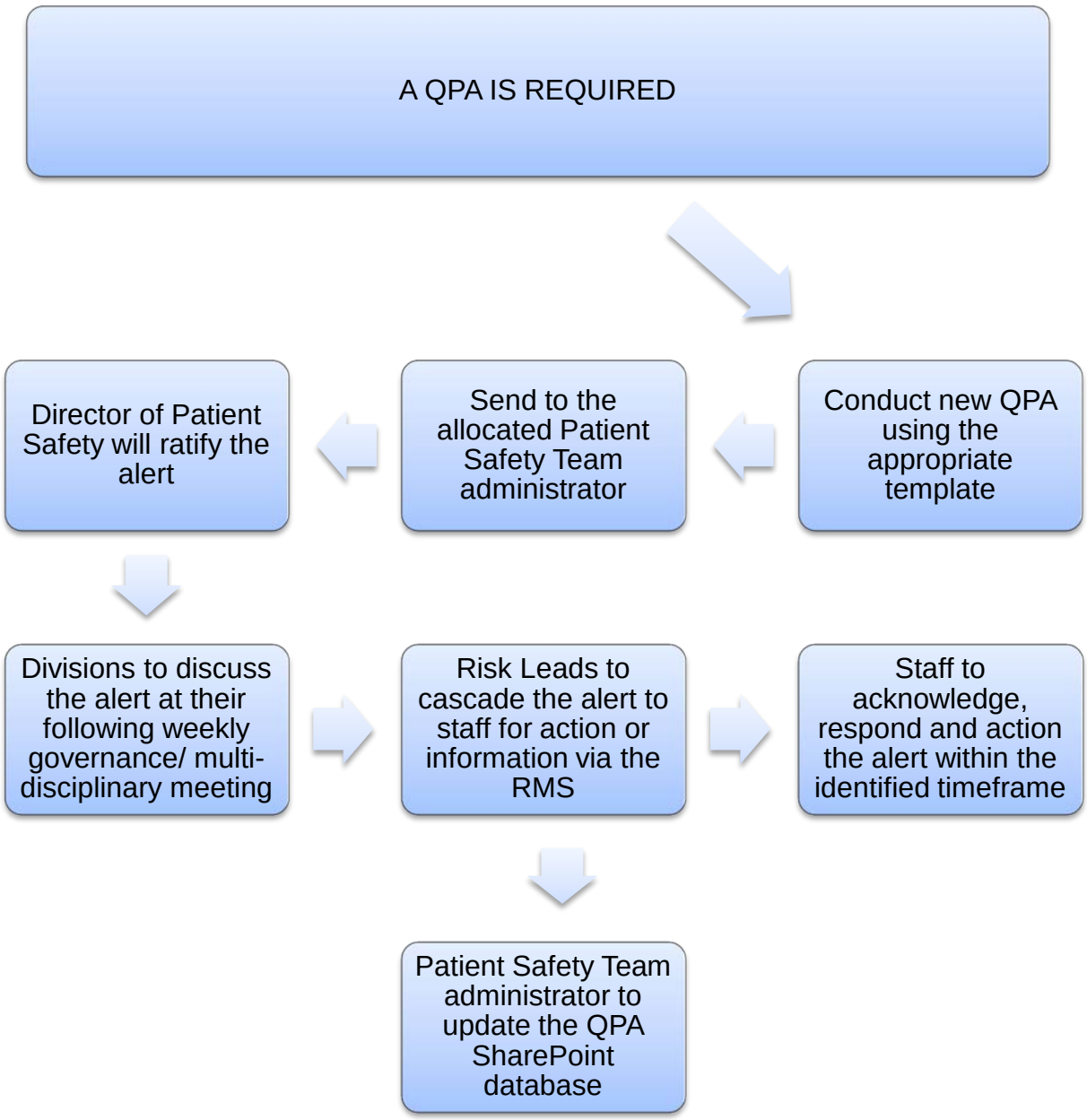
This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

| Category | Actions | Target date | Person responsible and their Directorate |
|---|---|---|---|
| **Involvement and consultation** | | | |
| **Data collection and evidencing** | | | |
| **Analysis of evidence and assessment** | | | |
| **Monitoring, evaluating and reviewing** | | | |

## Appendix A – Process for reviewing/ revising existing QPAs



**Appendix B – QPA Distribution Process**



**Appendix C – QPA Template**

| | |
|---|---|
| Urgent<br>  <br>New information/ Identified Learning<br>  | NHS<br>Mersey Care<br>NHS Foundation Trust<br>Community and Mental Health Services<br><br>**QUALITY PRACTICE ALERT** |
| Division this is related to: | Corporate ☐ Local ☐ Secure & Specialist Learning Disabilities ☐<br>Community Services Division ☐ |
| Responder(s) | |
| For information | |
| Date Issued | |
| Reference Issued | ***Please leave this space blank*** |
| Title | |
| QPA Author | |
| **IDENTIFIED ISSUE/ TOPIC/ RISK FOR CONSIDERATION** | |
| | |

| **Actions Required** | **Action** | **By who** | **Deadline** |
|---|---|---|---|
| | | | |

| | Area | Lead | Contact Information |
|---|---|---|---|
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