# Patient Safety Partner (PSP) Expression of Interest Form

**PSP information**

|  |  |
| --- | --- |
| Name: |  |
| Address (to include postcode) |  |
| Telephone contact numbers  |  |
| Email address(if you do not have your own email address, please provide one where information can be sent to):  |  |
| Are you currently a carer (paid or unpaid)?  | Yes/No If yes, please give more detail |

**PSP experience and availability**

|  |  |
| --- | --- |
| What time would you be able to commit to PSP involvement? i.e., hours per day, week, month(For discussion when we meet) |  |
| Tell us briefly about any relevant experience in paid employment or as a volunteer, ie organisation, roles.  |  |
| Tell us briefly about any lived experience you would like to share, that would be relevant to this role. Lived experience means you have **personal** knowledge about a health and care topic through direct, first-hand involvement.  |  |

**Skills/qualifications**

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| Please tell us about any skills or qualifications you feel are relevant to the PSP role in which you are interested. These could be specific skills from previous roles or lived experience, or could be personal skills such as flexibility, communication skills or being well organised. |
|  |

**Motivation for becoming a PSP**

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| What has made you decide to apply to become a PSP and what would you hope to get out of this role?  |
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| Are you a member of any other groups or networks that would be relevant to this role? |
|  |

**Other**

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| Tell us anything else about you that would be relevant to the role |
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| Are there any reasonable adjustments that you need as part of this process? |
|  |
| How did you hear about this role? (this may help us with future recruitment of PSPs) |
|  |

**Referees**

Please give the names and addresses of two people who you have known for at least 12 months and are not family members; we will contact them before appointment.

|  |  |  |
| --- | --- | --- |
|  | Referee 1 | Referee 2 |
| Name |  |  |
| Address(Inc: Postcode)  |  |  |
| Telephone number  |  |  |
| Email address  |  |  |
| How do you know this person? |  |  |

**Disclosure and barring**

We ask everyone who works with vulnerable people in a voluntary capacity to disclose all convictions, including spent ones. This requirement is covered by the exemption order of 1975 relating to sections 4(2) and 4(3b) of the Rehabilitation of Offenders Act 1974.

|  |  |
| --- | --- |
| Do you have any criminal convictions/cautions? | Yes/No |

If yes, please give details in a separate letter and send this with your application form in an envelope marked ‘Confidential’.

Please note, a criminal record will not necessarily prevent you from working with us; however, we reserve the right to conduct checks as necessary with the Disclosure and Barring Service (DBS).

**Data protection**

The information provided on this application form will remain private and confidential and will be used for the purpose of selection. We may wish to process this information for administration, and this will be done in accordance with the provisions of the Data Protection Acts 1984 and 1998.

We may approach third parties such as your referees to verify the information that you have given. By signing this form, you are giving consent to all these uses.

**Eligibility to work as a PSP**

Individuals from outside the UK who work as a PSP with us are recommended to check their visa/entry clearance conditions before applying, to make sure they are allowed to do voluntary/unsalaried work.

**Expenses and Renumeration**

Patient Safety Partners will be paid in line with the national involvement payments developed by NHS England. This includes involvement payments of £150 per day or £75 per half day when supporting certain areas such as strategic level Committees and key decision-making groups.

For other working groups including policy development, reasonable out-of-pocket expenses are covered.

**Declaration**

* The statements made by me in this application are to the best of my knowledge true.
* I confirm I have read and understood the information above.

Signature of applicant: ................................................. Date: ...............................

Please return your completed form either by email to medwayft.patientsafetyteam@nhs.net or by post to:

Jessica Campbell

Patient Safety Specialist

Level 1 Green Zone, Governance office

Medway Maritime Hospital

Windmill Road

Gillingham

ME7 5NY

**Please mark your envelope ‘Private and confidential’.**