| Reference Number: UHB 138<br>Version Number: 5 | Date of Next Review: *November 2027*<br>Previous Trust/LHB Reference Number: |
|---|---|

## INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

**Policy Statement**

**The UHB is committed to ensuring the quality of care provision and the safety of patients, service users, visitors and staff and to reducing the number of untoward incidents. The UHB will ensure that its statutory requirements for reporting untoward incidents is met.**

It is essential that all incidents, near misses and hazards are reported so that appropriate action can be taken to try to prevent their reoccurrence, improve the environment, patient experience and services where appropriate action can be taken to reduce risk of recurrence.

The Policy defines Incidents, Hazards and Near misses:-

- **Incident**

  An *Adverse Incident* is defined as "any unplanned event that resulted in, <u>or had the potential to result in</u>, an injury or the ill health of any person, or the loss of, or damage to, property"

  A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS funded healthcare (National Policy on Patient Safety Incident Reporting and Management, NHS Wales, 2023

- **Hazard**

  A hazard is a source of potential harm or damage or a situation with potential for harm or damage.

- **Near Miss**

  A *near miss* is an occurrence, which but for the luck or skilful management would in all probability have become an incident.

- **National Patient Safety Incident**

  A National Patient Safety Incident is a patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare".

  The above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community services

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1.6     When considering whether to report a National Patient Safety Incident to NHS Executive the following should be applied:

- a patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm.

- as it will not always be possible to determine the extent to which a patient safety incident caused or contributed to the harm or death of a patient within seven working days, responsible bodies should report in line with the criteria where it is known, and/or suspected, that a patient safety incident has caused or contributed to harm or death. In this scenario, for clarity, the responsible body should specify on the form that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date as set out later in this guidance.

- all such incidents must be reported to the NHS Executive within seven working days from the occurrence, or point of knowledge. See Section 1.7 for exceptions to this

1.7a Specific National Patient Safety Incidents that should be reported to NHS Executive immediately:

- Suspected suicide or self-inflicted death in any clinical setting or during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge
- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months.
- Never Event – all Never Events are defined as National Patient Safety Incidents although not all Never Events necessarily result in severe harm or death;
- Incidents where the number of patients affected is significant such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure. The key wording in this reporting requirement is "the number of patients affected is significant".
- Unusual, unexpected or surprising incidents where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial
- Maternal, perinatal and infant deaths

1.7b    Certain types of patient safety incidents can be reported retrospectively as Nationally Reportable Incidents

- Avoidable health acquired pressure damage – must be reported within 60 days from the date of identification of the incident.
- Avoidable in-patient falls resulting in any significant fracture or significant injury – must be reported within 60 days from the date of identification of the incident.
- Medically unexpected death in the community of patients who have been in contact with Mental Health and/or Learning Disability Services in the last year – must be reported within 120 days from the date of identification of the incident.

For more information relating to NHS Wales National Incident Reporting Policy click here

1.8    1.8    **RIDDOR** is the recognised abbreviation for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations2013.

These Regulations specify the accidents, ill health and dangerous occurrences that arise out of or in connection with work, that must be reported to the Health and Safety Executive by the Health and Safety Department. This includes:

- An *over 7-day injury* – an accident that results in an employee being away from work or unable to perform their normal duties for more than seven consecutive days as the result of their injury, not including the day of the incident. The seven-day period does not include the day of the accident but does include weekends and rest days.
- A *Specified Injury,* for example a fracture or serious burns.
- A *Dangerous Occurrence* is a certain specified near miss event, which may not result in a reportable injury, but have the potential to cause significant harmFor example, a needlestick injury from a known Blood Bourne Virus source is reportable as a Dangerous Occurrence.
- A *Reportable Disease* – a disease that may arise from an individual's occupation. They are specified in Schedule 3 of RIDDOR. Such diseases have to be diagnosed by a Registered Medical Practitioner and the person's job undertakes work linked with that condition. Should a member of staff advise that they are absent from work, for over 7 days, due to an injury sustained at work, the Manager must ensure that the relevant Health and Safety Advisor is advised of this at the earliest opportunity. This action should be taken even if it is some time after the incident and the information comes to light as part of the sickness review process.

Further information can be found can be found on the Health and Safety Share Point page using the link below.

IMS Information Management System HomePage (sharepoint.com)

**Cardiff and Vale UHB encourage an open and just culture. The aim of reporting and investigating incidents, near misses and hazards is not to apportion blame but rather to learn from the event and to minimise the risk of reoccurrence.**

**Policy Commitment**

To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive sound governance-framework.

To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff and patient safety and well-being.

To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting

**Supporting Procedures and Written Control Documents**

- Incident, Hazard and Near Miss Reporting Procedure
- Health and Safety Policy
- Policy for Reporting Research Related Events
- Being Open Policy
- Records Management Policy
- Risk Management Policy

**Other supporting documents are:**

- Procedure on Reporting Research Related Adverse Events
- Risk Assessment and Risk Register Procedure
- Investigation Procedure
- Duty of Candour
- Just Culture

**Scope**

This policy applies to all staff employed by the UHB, including those with honorary contracts. It also applies to students and locum/agency staff working within UHB facilities/under contract to the UHB.

This Policy also applies to contractors who have a statutory responsibility to report accidents that have occurred on UHB sites.

| Equality and Health Impact Assessment | An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact |
|---|---|
| Policy Approved by | Health and Safety Committee |
| Group with authority to approve procedures written to explain how this policy will be implemented | Operational Health and Safety Group<br>Clinical Board Health and Safety Groups and Patient Quality and Safety Groups |
| Accountable Executive or Clinical Board Director | Director of Corporate Governance<br>Executive Director of Nursing |

**Disclaimer**
**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**

**Summary of reviews/amendments**

| Version Number | Date Review Approved | Date Published | Summary of Amendments |
|---|---|---|---|
| 1 | 18/09/2012 | 26/09/2012 | Trust Incident Reporting and Investigation Procedure reviewed and updated. Replaces previous Trust document reference no: 108 |
| 1.1 | 09/04/2013 | 14/06/2013 | New Appendix 9 added – Internal Management of HM Coroner Rule 43 Reports by Patient Safety Team |
| 2 | 18/07/2017 | | To reflect changes as a result of the introduction of E Datix and to simplify by segregating the policy from the procedure |
| 3 | | | Definitions of patient safety incidents updated. Fair culture updated to reflect just culture in line with recent guidance. |
| 4 | | | Updated to reflect changes in National Reporting guidance issued by the NHS Wales Delivery Unit. |
| 5 | | August 2023 | Updated to reflect changes in National Reporting guidance issued my NHS Executive |
| 6 | Nov 2024 | Feb 2025 | Updated to include DoC and timeframes |

## 2. ROLES AND RESPONSIBILITIES

2.1 The **Chief Executive** is ultimately responsible for ensuring compliance with the Health and Safety at Work etc Act 1974 and associated legislation including NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, and that the Incident, Hazard and Near Miss Reporting Policy and these associated procedures are implemented effectively within Cardiff and Vale University Health Board.

2.2 The **Executive Nurse Director** is the lead Executive with responsibility for clinical governance/patient safety and quality. The Executive Medical Director and Executive Director of Therapies and Health Sciences also have responsibilities in relation to these matters within their professional groups.

2.3 The **Executive Director of Governance** has Board level responsibility for health and safety which includes Health and Safety risks and incident management.

2.4     The **Assistant Director of Patient Safety and Quality** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical/Service Boards to enable timely reporting and review of incidents.

2.5     The **Head of Health and Safety** supports the development of arrangements for incident reporting and is responsible for providing assurance to the Executive Directors that appropriate systems and processes are in place for health and safety related incident reporting, management and monitoring. The post holder will also ensure that the appropriate level of support is provided to the Clinical Boards to enable timely reporting and review of health and safety incidents.

2.6     The **Patient Safety Team** and **Health, Safety and Environment Unit** are responsible for supporting the implementation of this procedure. They will also undertake to raise staff awareness and training on incident reporting and investigation.

2.7     The **Clinical Board Triumverates** are responsible for ensuring that staff within their Board are briefed on their individual and collective responsibilities within the incident reporting process. They must ensure that all incidents are reported, investigated and analysed, so that learning and improvements can be embedded in practice.

2.8     **Department Managers** are responsible for cascading the procedure to staff ensuring that they are fully conversant with the process to be followed for all incidents.

        Department/Line Managers are responsible for reviewing, escalating, taking appropriate action and feeding back to incident reporters in a timely manner in line with UHB procedures.

        All incidents will be reviewed appropriately on Datix Cymru. Best practice is to complete an initial "make safe" review within 3 working days of the incident being reported.

        Significant incidents, for example, those that may require onward reporting to an external agency must be escalated promptly with actions recorded on the electronic incident reporting system. NHS Executive expects National Patient Safety Incidents to be reported to them via the Patient Safety

Team within 7 days of the incident occurring where possible (please see section 1.7b for exceptions).

There is an expectation that incidents reported on the electronic reporting tool will be reviewed by the relevant manager within 3 days.  Where possible, incidents should be concluded within 30 days.  More complex incidents, for example National Patient Safety Incidents reported to the NHS Executive should be concluded within the agreed timeframe (30, 60, 90 or 120 days) in order to comply with the NHS Executive closure process.

It is imperative that managers review and conclude incidents in a timely manner in order that the UHB fulfils its quality, safety and governance responsibilities within appropriate timescales.

Department/Line Managers are responsible for ensuring that an appropriate review is undertaken for all incidents that have occurred in their area of responsibility and ensuring that measures to prevent recurrence are implemented within the shortest appropriate timescale.  Timeframes regarding general incidents and National Patient Safety Incidents have been outlined in Section 2.8.  RIDDOR incidents are to be investigated within 21 days although there will be exceptions for more serious incidents.  Incidents which are also investigated by the Health and Safety Executive may result in an extended investigation period.

It is the responsibility of Department/Line Managers to ensure that appropriate disclosure of incidents is made to patients and their families in line with the UHB's Being Open Policy and Welsh Government NHS Duty of Candour.

It is also important that Department/Line Managers are conversant with the Just Culture Guidance from NHS Improvement in order that the appropriate support can be provided to staff.  The guidance can be accessed here

2.9     **All employees** are responsible for ensuring that the immediate area and staff and patient safety is secured following an adverse incident.  The incident must be promptly reported to an appropriate senior member of staff if significant harm or injury has occurred. Employees must ensure the incident is reported on the electronic incident reporting tool provided by the UHB, available via SharePoint, as soon as it is safe and practical to do so.  The incident form can be accessed here. If it is not possible to report an incident promptly, the reason for the delay in reporting should be documented within the incident form.

Employees may be required to provide additional information on incidents during investigations; this may include provision of statements or attendance at interviews.

Under the Safety Representatives & Safety Committees Regulations 1977, **Safety Representatives** are also allowed to investigate: potential hazards, dangerous occurrences, and causes of accidents and occupational ill-health within the area of their responsibility.

2.10 **Contractors** such as estates and equipment maintenance contractors and building contractors have a statutory responsibility to report adverse incidents, hazards and near misses that have occurred on UHB sites to the UHB in line with their contract arrangements.

## 3. TRAINING

3.1 Information on incident reporting is provided to all staff on induction and supporting materials are available on SharePoint on the DatixCymru incident reporting pages.

3.2 Incident reporting is included in Health and Safety mandatory training through an e-learning module or via face to face presentation.

3.3 Incident reporting procedures must be included in local departmental induction.

3.4 Support for staff is available via a Datix Help Desk, SharePoint DatixCymru page and Datix Superuser Group.

3.5 Training for line managers who require log-in to the electronic incident reporting system will be provided by the Patient Safety Team and Health, Safety and Environment Unit.

3.6 Incident investigation training is provided by the Patient Safety Team.

## 4. ADVERSE INCIDENT, HAZARD AND NEAR MISS REPORTING AND MANAGEMENT

4.1 When an incident occurs staff must first ensure the people or area concerned are made safe.  The incident must be reported through the recognised UHB incident reporting mechanisms, this being the Datix system available on SharePoint; a link is provided in Section 2.9.

All incidents will be graded according to the actual impact on the individual(s) involved using the Duty of Candour Levels of Harm Framework  which can be accessed [here](here)

|  |  |
|---|---|
| No harm | Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen |
| Low harm | Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care |
| Moderate harm | Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or |

| | | transfer to another treatment area such as intensive care |
|---|---|---|
| | Severe harm | The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition |
| | Death | A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition |

Staff are also able to reflect the potential future risk to individuals and to the organisation on the incident reporting system.

Incidents should be reported as soon as possible after the event. Where this is not possible, an explanation must be given for the reason for the delay in reporting.

### 4.2 Duty of Candour

If adverse events have occurred to patients, the incident should be communicated to the patient or their representative as soon as is practical. There is a requirement that incidents of moderate, severe and catastrophic harm will be disclosed in line with Duty of Candour. In exceptional circumstances, if it is deemed that the impact of disclosure will adversely affect the patient's psychological wellbeing, a decision may be taken not to inform the patient. Reasons for this decision must be clearly documented in the patient's health records. Advice can be sought from the Patient Safety Team.

Further guidance on Duty of Candour can be found here

### 4.3 National Patient Safety Incidents

If a National Patient Safety Incident occurs, supporting information to guide staff can be located on the Patient Safety and Quality pages on SharePoint. .

The organisation recognises that National Patient Safety Incidents or incidents requiring review may be potentially stressful and difficult for staff, patients and their families. It is essential that appropriate and timely support is offered and made available to everyone involved.

### 4.4 Never Events

Never Events are defined as National Patient Safety Incidents that are wholly preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Never Events require full investigation under the National Policy on Patient Safety Incident Reporting and Management . This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.

Never Events are managed in the same way as Nationally Reportable Incidents and supporting information can be found on the Patient Safety and Quality pages on SharePoint..

Further information from Welsh Government on Never Events can be found on the Patient Safety Wales website

### 4.5 Supporting staff to report incidents and following an incident occurring

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about their concerns allows valuable lessons to be learnt so issues can be dealt with and prevented from being repeated.

The UHB actively encourages staff to raise concerns about safety. If for any reason they feel unable to report an incident in line with this procedure, there are other routes for them to raise their concerns. These would include Freedom to Speak Up, Safety Valve and Whistleblowing Policy.

The UHB recognises that being involved in an adverse incident can have devastating effects on staff. It is vital that the appropriate supporting mechanisms are put in place.

The Just Culture Guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Further information can be found here.

### 4.6 Legal Status and Retention of Incident Reports

It is a requirement of WHC 2000(71) that Incident Reports relating to adults will be retained for ten years after the date of the incident, and Incident Reports relating to incidents involving children will be retained until the child is 25 years of age or for eight years after the death of the child (whichever is the sooner).

The electronic incident reporting system fulfils the requirement of the UHB to maintain accident book(s) at strategic locations in accordance with the Social Security (Claims and Payments) Regulations 1979.

### 4.5 Reporting Information Governance breaches

Events of failure to comply with information governance requirements are considered to be an incident and should be promptly reported using the electronic incident reporting system.

These events can be viewed by the Information Governance Department for appropriate further action, monitoring of investigation and remedial actions.

On occasion, onward reporting to the Information Commissioner may be required. Appropriate incidents must be reported to the Information Commissioner within 72 hours of the incident occurring and so prompt incident reporting and review by line managers is of critical importance. Further guidance can be sought from the Information Governance Department.

## 4. REVIEW

Reviews will be proportionate to the incident that has occurred.

Reviews may also be undertaken if there is repetition of similar incidents or clusters of incidents.

Due consideration must be given to the independence of the reviewing officer in order that the UHB and its staff, patients and their families can have confidence in the transparency of the review process.

Guidance on how to carry out a Patient Safety Learning Review is available on the Patient Safety and Quality pages on SharePoint.

Information is available on the Patient Safety and Quality pages on SharePoint to support staff who are required to write a statement following an adverse incident.

The Patient Safety Team will provide training on how to undertake a Patient Safety Learning Review and maintain a record of staff who have attended the training.

There is an expectation that staff who attend training will support the review of patient safety incidents across the UHB.

Timeframes for review of incidents are outlined in Section 2.8.

## 6. REPORTING TO EXTERNAL AGENCIES

Some specified incidents are required to be reported to external agencies. The National Incident Reporting Toolkit and standard agenda template prompt attendees at the fact-finding meeting to consider whether communication with external agencies is required.

Communication with external agencies will be undertaken through the agreed UHB incident reporting mechanisms by the appointed persons as outlined below. It should be noted that this list is not exhaustive.

| External Agency | Requirement | Appointed Department |
|---|---|---|
| **Health and Safety Executive - RIDDOR** The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 | Work related deaths, specified injuries, dangerous occurrences and accidents resulting in over 7 day injury which results in incapacity to undertake normal work duties. Also specified diseases. | The Health and Safety Department Occupational Health Department |
| *NHS Wales National Policy on Patient Safety Incident Reporting and Management May 2023* | Reporting of National Patient Safety Incidents to the NHS Executive should be undertaken within 7 working days (see section 1.7b for exceptions) and Early Warning Notification to Welsh Government should be undertaken as soon as is practicable. | Patient Safety Team |
| **Medicines and Healthcare Products Regulatory Agency (MHRA)** | Incidents involving a medicine or medical device may be reportable to the MHRA. Breaches to the Blood Safety and Quality Regulations may be reportable to the MHRA as Serious Adverse Blood Reactions or Events. | UHB nominated liaison officer in Pharmacy or Clinical Engineering respectively Blood Transfusion Team |
| **Communicable Diseases** | In the event of an infectious disease outbreak and any serious single infection with public health implications. | The Consultant in Communicable Disease Control, Health Protection Agency (HPA) should be contacted |
| **Healthcare Inspectorate Wales – Ionising Radiation Medical Exposure Regulations (IRMER)** | Breaches in IRMER to Healthcare Inspectorate Wales. Such incidents will also be reported to the Delivery Unit in line with National Incident reporting if the incident is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to severe harm or death | Patient Safety Team |
| **Information Commissioner (ICO)** | Breaches of the Data Protection Act may require reporting to the Information Commissioner. | Information Governance Department |
| **Welsh Health Specialised Services Committee (WHSSC)** | WHSSC would expect to be informed of any incidents of a catastrophic nature to an individual; any incidents which raise concerns in relation to delivery of a particular commissioned service or emerging themes/trends. | Assistant Director of Patient Safety and Quality |

| | | |
|---|---|---|
| | The Assistant Director of Patient Safety and Quality and Patient Safety Team representative meet with WHSSC on a regular basis where appropriate concerns are raised for discussion. | |
| **Human Tissue Authority (HTA)** | Breaches of the Human Tissue Act require reporting to the Human Tissue Authority under the Human Tissue Authority Reportable Incident (HTARI) process. Reporting guidance can be found here | Designated Individual or Deputy. |

## 7.   IMPLEMENTATION

This procedure reflects existing practice across the UHB and will therefore be implemented with immediate effect.  The requirements of this procedure will be re-enforced within Clinical Boards and Directorates/Departments by local risk management, health and safety and quality and safety arrangements.

## 8.   EQUALITY

We have undertaken an Equality Impact Assessment and received feedback on this policy and procedure and the way it operates.  We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, maternity and pregnancy, carer status, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.  The assessment found that there was no adverse impact to the equality groups mentioned.  Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

## 9.   MONITORING

It will be necessary to ensure that Clinical Boards are adhering to the requirements of this procedure.  This will be monitored via a number of agreed performance indicators.

The Quality, Safety and Experience Committee and Health and Safety Committee will monitor implementation of this policy.

## 10. DISTRIBUTION

10.1 This procedure will be available on the UHB SharePoint and Internet Site.

10.2 Line Managers/Departmental Managers/Lead Nurses/Directorate Managers/Clinical Directors are responsible for ensuring that all staff have access to this document.

## 11. REVIEW

This procedure will be reviewed every three years or sooner if required.

## 12. FURTHER INFORMATION/REFERENCES

HSE (1994), *Management of Health and Safety in the Health Service*, Health Service Advisory Committee, Health and Safety Executive.

HSE (1995) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.*

HSE Reporting injuries, diseases and dangerous occurrences in health and social care – Guidance for employer. HSE Health Services Information Sheet No 1 (Revision 2)

*Ionising Radiation (Medical Exposure) Regulations 2017*

NPSA (2006), *Being open: Communicating patient safety incidents with patients, their families and carers* (Re-launched 2009)

NPSA (2004), *Seven Steps to Patient Safety*

Social Security (1987), Claims and Payments Regulations No 1968 Welsh Government *Putting Things Right/NHS Redress (Guidance November 2013)*

Welsh Government (2015) Health and Care Standards

Welsh Government (2004) *Medical Device Alert 054: Reporting Adverse Incidents – Guidance on New Arrangements for NHS Wales Organisations*

# Equality & Health Impact Assessment for

# INCIDENT, HAZARD AND NEAR MISS REPORTING POLICY

Please answer all questions:-

| 1. | For service change, provide the title of the Project Outline Document or Business Case and Reference Number | Incident, Hazard and Near Miss Reporting Policy |
|---|---|---|
| 2. | Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details | Executive Services – Director of Corporate Governance<br><br>Author- Head of Health and Safety – 43751 |
| 3. | Objectives of strategy/ policy/ plan/ procedure/ service | • To ensure that all adverse incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.<br><br>• To promote a culture in which incidents are reported and investigated appropriately and to ensure that lessons can be learnt from adverse incidents and near misses to promote the continued improvement of staff safety and patient well-being.<br><br>• To enable the UHB to comply fully with legislation and mandatory requirements in relation to incident reporting |
| 4. | Evidence and background information considered. For example<br>• population data | |

| | | |
|---|---|---|
| | • staff and service users data, as applicable<br>• needs assessment<br>• engagement and involvement findings<br>• research<br>• good practice guidelines<br>• participant knowledge<br>• list of stakeholders and how stakeholders have engaged in the development stages<br>• comments from those involved in the designing and development stages<br><br>Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2]. | |
| **5.** | Who will be affected by the strategy/ policy/ plan/ procedure/ service | All Staff and Patients |

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[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

## 6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **6.1 Age** <br> For most purposes, the main categories are: <br> • under 18; <br> • between 18 and 65; and <br> • over 65 | The incident reporting database details age of victim, which allows for subsequent analysis. | | |
| **6.2 Persons with a disability as defined in the Equality Act 2010** <br> Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes | No Impact | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
| --- | --- | --- | --- |
| **6.3 People of different genders:** Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender | The incident reporting database details gender of victims, which allows for subsequent analysis. | | |
| **6.4 People who are married or who have a civil partner.** | No Impact | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.**  They are protected for 26 weeks after having a baby whether or not they are on maternity leave. | No Impact | | |
| **6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers** | The incident reporting database records incidents which are related to racial aspects. | | |
| **6.7 People with a religion or belief or with no religion or belief**. | As above | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| The term 'religion' includes a religious or philosophical belief | | | |
| **6.8 People who are attracted to other people of**:<br>• the opposite sex (heterosexual);<br>• the same sex (lesbian or gay);<br>• both sexes (bisexual) | The incident reporting database covers homophobic and sexual related incidents. | | |
| **6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design**<br><br>Well-being Goal – A Wales of vibrant culture and thriving Welsh language | The database includes a racial aspect, which has included Welsh. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| | | | |
| **6.10 People according to their income related group:** Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health | No Impact | | |
| **6.11 People according to where they live:** Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities | No Impact | | |
| **6.12 Consider any other groups and risk factors relevant to this strategy,** | Incident reporting is available to all staff, through all UHB | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **policy, plan, procedure and/or service** | electronic outlets i.e. computers. | | |

### 7.  HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| **7.1 People being able to access the service offered:** Consider access for those living in areas of deprivation | | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| and/or those experiencing health inequalities<br><br>Well-being Goal - A more equal Wales | | | |
| **7.2 People being able to improve /maintain healthy lifestyles:**<br>Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, | The incident reporting database allows for analysis of events with a clear aim to improve patient care and staff working conditions. | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| weight management services etc<br><br>Well-being Goal – A healthier Wales | | | |
| **7.3 People in terms of their income and employment status:**<br>Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions<br><br>Well-being Goal – A prosperous Wales | No Impact | | |
| **7.4 People in terms of their use of the physical environment:** | The incident reporting database collects data in relation to environmental events, which allows for | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces<br><br>Well-being Goal – A resilient Wales | analysis and appropriate resolution. | | |
| **7.5 People in terms of social and community influences on their health:** | No Impact | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos<br><br>Well-being Goal – A Wales of cohesive communities | | | |
| **7.6 People in terms of macro-economic, environmental and sustainability factors:** Consider the impact of government policies; gross domestic product; economic | No Impact | | |

| How will the strategy, policy, plan, procedure and/or service impact on:- | Potential positive and/or negative impacts and any particular groups affected | Recommendations for improvement/ mitigation | Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate |
|---|---|---|---|
| development; biological diversity; climate<br><br>Well-being Goal – A globally responsible Wales | | | |

**Please answer question 8.1 following the completion of the EHIA and complete the action plan**

| **8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service** | Positively supports equality issues, through facilitating reporting of related events and requires managers to progress actions, towards resolution. |
|---|---|

# Action Plan for Mitigation / Improvement and Implementation

| | Action | Lead | Timescale | Action taken by Clinical Board / Corporate Directorate |
|---|---|---|---|---|
| **8.2 What are the key actions identified as a result of completing the EHIA?** | To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed to the health, safety and welfare of its staff, patients, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of untoward incidents. | | | |

| | Action | Lead | Timescale | Action taken by Clinical Board / Corporate Directorate |
|---|---|---|---|---|
| **8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?**<br><br>This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required? | N/A | | | |

| | Action | Lead | Timescale | Action taken by Clinical Board / Corporate Directorate |
| --- | --- | --- | --- | --- |
| **8.4 What are the next steps?**<br><br>Some suggestions:-<br>• Decide whether the strategy, policy, plan, procedure and/or service proposal:<br>   o continues unchanged as there are no significant negative impacts<br>   o adjusts to account for the negative impacts<br>   o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)<br>   o stops.<br>• Have your strategy, policy, plan, procedure and/or service proposal approved<br>• Publish your report of this impact assessment<br>• Monitor and review | N/A | | | |