**Incident reporting policy and procedure**

**Author:** Mark Dickinson, Director of Planning and Performance  
**Date:** 10 June 2013  
**Version:** 1

**Purpose and Summary of Document:**  
The purpose of this paper is to introduce the incident reporting policy and procedure.

**Sponsoring Executive Director:**  
Mark Dickinson, Director of Planning and Performance

**Who will present:**  
Mark Dickinson, Director of Planning and Performance

**Documents attached:**  
Incident reporting policy and procedure and Equality Impact Assessment.

**Date of Board meeting:** 27 June 2013

**Committee/Groups that have received or considered this paper:**  
This policy has been circulated in line with the policy consultation process.

**Please state of the paper is for:**

<table>
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<th>Discussion</th>
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1 Purpose
The Incident Reporting policy and procedure have been reviewed and updated to accompany the roll out of a new risk management database (DATIX). The DATIX database is used to report and manage all incidents, concerns, claims, risks and requests for information.

The policy and procedure aim to prevent, reduce and control risks in order to protect individuals and the organisation from unintended harm, damage or loss. The procedure establishes a process for dealing with incidents from occurrence, to investigation and closure. This ensures that all incidents are reported, managed and analysed in a consistent way.

This process includes a commitment to learning from events, ensuring that the reporting of incidents makes a positive contribution to continuous improvement.

2 Recommendation(s)
It is recommended that the Board approve the Incident Reporting policy and procedure.

3 Timing
The new DATIX database is now in operation and so it is recommended that this policy and procedure is implemented as soon as possible.

4 Financial Implications
There are no financial implications to the implementation of this policy.

5 Board Members are asked to:
To consider and approve the Incident Reporting policy and procedure.

6 Next Steps
If the Board approve this policy, it will replace the current Incident Reporting policy (Black 62.)
# Incident Reporting Policy

**Policy type:** Organisational  
**Policy reference number:** PHW32  
**Policy classification:** Risk Management  
**Author:** Gay Reynolds, Corporate Services Manager  
**Policy lead:** Gay Reynolds, Corporate Services Manager  
**Executive lead:** Mark Dickinson, Director of Planning and Performance  
**Date:** 02 April 2013  
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**Review Date:** June 2016  
**Approval date:**  
**Approving body:** Board

**Purpose and Summary of Document:** This document details Public Health Wales’ policy and procedure for managing, reporting, analysing and learning from incidents that arise in the course of Public Health Wales conducting its business. The aim is to ensure that all incidents are managed and analysed consistently, and effectively, within a supportive environment and that lessons are learnt in order to reduce risks for the future.

**Intended audience:** All Staff

**Interdependencies with other policies:**  
Risk Management Strategy, Information Governance Policy, Risk Assessment Policy, Putting Things Right Policy, Being Open Policy, Claims Handling Policy and Procedure, Whistle Blowing Policy

**Standards for Health Services in Wales:** Standard 1, Standard 22  
Standard 23
## Policy consultation circulation list

<table>
<thead>
<tr>
<th>Group/Lead policy circulated to</th>
<th>Date circulated</th>
</tr>
</thead>
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<tr>
<td>Information Government Leads</td>
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</tr>
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</tr>
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</tr>
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<td>Equality Impact Assessment</td>
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<tr>
<td>All Staff (six week consultation)</td>
<td>08/02/13-22/03/13</td>
</tr>
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</tr>
<tr>
<td>Partnership Forum</td>
<td>31/05/13</td>
</tr>
</tbody>
</table>
Contents Page

1 INTRODUCTION ........................................................................................................ 6
2 POLICY AIMS AND OBJECTIVES ........................................................................ 6
3 SCOPE ..................................................................................................................... 7
4 LEGISLATIVE AND NATIONAL INITIATIVES ......................................................... 7
   4.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 ................................................................. 7
   4.2 Social Security Claims and Payments Regulations 1979 ............................. 7
   4.3 The Management of Health and Safety at Work Regulations 1999 8
   4.4 The Public Interest Disclosure Act 1998 ...................................................... 8
5 DEFINITIONS ........................................................................................................... 8
   5.1 Incident ............................................................................................................. 8
   5.2 Near Miss’ Incidents ...................................................................................... 8
   5.3 Incident (Clinical) .......................................................................................... 9
   5.4 Incident (Non-Clinical) .................................................................................. 9
   5.5 Serious Incidents (SI) .................................................................................... 9
6 ROLES AND RESPONSIBILITIES ......................................................................... 10
   6.1 Staff generally .............................................................................................. 10
   6.2 Person responsible for the immediate management of the incident ........... 10
   6.3 Managers ....................................................................................................... 11
   6.4 Divisional Directors ..................................................................................... 11
   6.5 Host Organisations ....................................................................................... 12
   6.6 Independent Contractors ............................................................................ 12
   6.7 Corporate Services Manager ...................................................................... 12
   6.8 Public Health Wales Wide Leads ................................................................. 12
   6.9 Director of Communications ...................................................................... 12
7 STAFF SUPPORT ................................................................................................... 13
8 NO BLAME CULTURE ............................................................................................ 13
9 PROCESS FOR LEARNING AND PROMOTING IMPROVEMENTS .................. 14
10 TRAINING AND COMMUNICATION WITH STAFF ....................................... 15
11 MONITORING AND AUDITING ......................................................................... 15
12 INFORMATION GOVERNANCE STATEMENT .................................................. 16
1 Introduction

As part of Public Health Wales’ commitment to the management of risk, in order to improve the quality of services and provide a safe environment for service users, staff and visitors, an organisation wide Incident Reporting System for reporting adverse incidents/accidents has been put in place.

This policy is based on a proactive approach to prevent, reduce and control risks in order to protect service users, the public, staff and the organisation from unintended harm, damage or loss. This includes a commitment to apply lessons learnt from incidents in order to reduce risks in the future.

This policy aims to ensure that all incidents are reported, managed and analysed consistently, and effectively, within a supportive environment and that lessons are learnt in order to reduce risks for the future.

Public Health Wales has a duty to ensure that those involved in or affected by incidents receive appropriate help and support.

2 Policy aims and objectives

Public Health Wales recognises that most incidents occur because of problems with systems rather than with individuals. The aim of this policy is therefore not to allocate individual blame but to ensure that there is organisational learning from incidents to reduce future risk and to provide support for any service users, staff, visitors and the public involved.

Public Health Wales aims:

- To ensure that the reporting of incidents makes a positive contribution to continuous improvement
- To identify factors contributing to incidents and gain a better understanding of how they arise
- To identify trends, locally and Trust wide
- To provide a means for identifying preventative measures or procedural changes that need to be made in order to eliminate or reduce risk of accident, injury, damage or loss
- To help ensure the safety of service users, staff and visitors and to reduce the costs of litigation
- To ensure that service users and partners receive appropriate information about incidents in which they were involved
- To provide feedback to Divisions / Teams and appropriate wider audiences so that the information may be used for learning
To ensure that individuals receive a full and honest response, which provides an account of what happened, why it happened and, if appropriate, any actions taken to avoid recurrence.

It is the responsibility of all employees of Public Health Wales and anyone attending, working on or visiting any Public Health Wales premises or place where Public Health Wales provides services, to abide by this policy and to report any incidents or near misses in which they were either directly involved or have witnessed.

Public Health Wales seeks to encourage service users and other stakeholders to report incidents, to enable Public Health Wales to obtain a more complete picture of the risks that face the organisation and to improve services.

3 Scope

This policy covers all incidents and near misses involving staff, service users, visitors, contractors or any others to whom Public Health Wales owes a duty of care. It covers both incidents that occur within the clinical setting and those that occur within non-clinical areas and which are unrelated to clinical services, including Information Governance.

4 Legislative and national initiatives

4.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

In line with RIDDOR, Public Health Wales will report incidents of a specified nature to the Health and Safety Executive (HSE). These include:

- Injuries to staff which result in an absence from duty of 7 days or more
- Dangerous occurrences such as failure of lifting equipment, explosion, and failure of supporting structures
- The reporting of diseases.

4.2 Social Security Claims and Payments Regulations 1979

Public Health Wales has a legal obligation to report accidents and incidents and to pay staff sick pay if staff are entitled to it. It is therefore required (under the Social Security Claims and Payments Regulations 1979) to provide an accident book where employees or people acting on their behalf can enter details of accidents leading to injury.
The Datix incident database is the organisation’s ‘Accident Book’ as it is the repository for all incidents reported and is a record of what happened when an incident has occurred. Therefore all accidents and incidents should be reported on the Datix Web incident Form (DIF1).

4.3 The Management of Health and Safety at Work Regulations 1999

The basis of British Health and Safety Law is the Health and Safety at Work etc Act 1974, which sets out the general duties which employers have towards employees and members of the public, and which employees have to themselves and each other.

The Management of Health and Safety at Work Regulations is more explicit with regard to employers’ duties in the management of health and safety and the requirement for employers to carry out risk assessments.

4.4 The Public Interest Disclosure Act 1998

This Act gives significant statutory protection to employees who disclose information reasonably and responsibly in the public interest and are victimised as a result.

5 Definitions

5.1 Incident

The term “incident” is used in this policy to refer to any event which gives rise to, or has the potential to produce, unexpected or unwanted effects involving service users, staff, visitors on Public Health Wales premises or employed by the Trust, or loss or damage to property, records or equipment which belong to the Trust or are on Trust premises. It includes accidents, clinical incidents, death, security breaches, violence and aggressions, failures of equipment and information governance.

5.2 Near Miss’ Incidents

Where the incident did not result in harm, loss or damage, but could have, this is referred to as a ‘Near Miss’. This may be clinical or non-clinical.

Near miss reporting is just as important in highlighting weaknesses in systems, policies/procedures and practices. If near misses are reported, learnt from and any necessary corrective action taken, they can help to prevent actual incidents of harm, loss or damage from occurring.
5.3 Incident (Clinical)

‘An event or circumstance arising during clinical care of a service user that could have (i.e. ‘near miss’) or did lead to unintended or unexpected harm’.

Incidents involving patients are also known as ‘Patient Safety Incidents’ (PSIs).

The NPSA defines a PSI as ‘any unintended or unexpected incident which could have or did lead to harm for one or more patient receiving NHS funded healthcare’.

5.4 Incident (Non-Clinical)

‘An event or circumstance that could have (i.e. ‘near miss’) or did cause unexpected or unwanted harm, loss or damage to any individual(s) involved (including service users but not related to clinical care, staff, visitors etc) or damage to/loss of property/premises for which Public Health Wales is responsible’.

5.5 Serious Incidents (SI)

There is no single definition of an SI but in general terms it is defined as an incident that occurred in relation to NHS funded services and care, resulting in a serious outcome. For example:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public
• severe / permanent harm to one or more patients, staff, visitors or members of the public

In the event of an SI occurring, the requirement is for immediate reporting to the Corporate Services Manager. Please also refer to Incident Reporting procedure for information on how to deal with SIs.

6 Roles and responsibilities

The reporting and investigation of incidents plays a key part in all aspects of Public Health Wales’ management of risk. The Chief Executive is ultimately responsible for ensuring compliance with the Health and Safety at Work Act 1974, and associated legislation.

Responsibility for managing risk lies at a Corporate, Divisional, service and individual level. All members of staff have a responsibility and obligation to co-operate in full with this process.

Throughout this document the term Manager is use to refer to the person with line management responsibility for team, laboratory or programme.

6.1 Staff generally

Staff have a legal responsibility to report, in a timely manner, any incident (clinical or non clinical), near miss, accidents and serious incidents which has caused or has the potential to cause harm, loss or damage to any individual involved or loss or damage in respect of property or premises for which Public Health Wales is responsible. This includes any incident that has the potential to involve the Trust in either litigation or adverse publicity. Incidents should be reported as soon as possible, ideally within 24 hours but no later than 2 days after the incident.

Any member of staff who is involved in, witnesses or discovers an adverse incident/accident or near miss incident/accident should complete the Datix Web Incident Form (DIF1) which is available to all staff via the Public Health Wales intranet. Staff should also report incidents to their Manager.

In the event of an SI occurring, the requirement is for immediate reporting to the Corporate Services Manager.

6.2 Person responsible for the immediate management of the incident

The person responsible for the immediate management of the incident should undertake an immediate assessment of the situation, in order to determine any immediate treatment and/or ongoing care needs of the
affected person, and/or the extent of any loss/damage to property and any other immediate action required (e.g. removal and isolation of faulty equipment). The situation/area should be made safe.

6.3 Managers

All Managers are responsible for the safety of their workforce and service users and will ensure that systems of incident reporting are implemented within their area of responsibility. Managers should also record the immediate actions taken, which might include, making the area safe, wearing protective clothing, removal of similar equipment and undertake risk assessments.

Following every incident, whether a near miss or an incident resulting in injury or adverse incident, managers must review and record on the Datix DIF2 form any required immediate and/or preventative actions taken along with scoring the severity of the incident and ensuring that the incident is coded correctly.

The review should take place within 2 days of the incident being reported. This is important for ensuring the quality, accuracy and completeness of the incident reports.

Reviews of incidents will be routinely carried out by managers to ensure that agreed/proposed actions have been carried out, lessons learnt have been identified along with scoring the severity of the incident and risk grading.

6.4 Divisional Directors

Divisional Directors are responsible to the Board for implementing this policy and procedure. Divisional Directors will, through their Managers, ensure all staff, including temporary or agency staff, within their sphere of responsibility are aware of the need to report incidents, near misses and service user safety incidents using the electronic Datix Web Incident Form (DIF1).

Divisional Directors will be responsible for ensuring:

- That appropriate arrangements are in place within their Division for the reporting, investigation and follow-up of incidents in accordance with both this policy and in accordance with their responsibilities for governance and risk management;
- Incident data is reviewed in order to identify and monitor trends/problems, and for taking appropriate action
If an incident is identified as an SI the responsible Director will ensure that the procedure for SIs is followed and that full written contemporaneous records are maintained of all actions taken and uploaded on to Datix.

6.5 Host Organisations

Where an incident occurs involving a host organisations, details of the incident will be shared and joint investigations undertaken as appropriate.

6.6 Independent Contractors

Independent Contractors are expected, as part of their professional duty, to report all incidents to Public Health Wales, which will be recorded using the Datix Web Incident Form (DIF1).

6.7 Corporate Services Manager

The Corporate Services Manager will be responsible for:

- The overall management and co-ordination of the organisation’s incident reporting arrangements including the Datix incident database
- The reporting of incidents, as necessary, to the relevant external agencies
- The compilation of analysis reports (e.g. for Quality and Safety Committee, Information Governance Committee, Risk Management Group, Health and Safety Group, Information Governance Working Group, Infection Control Group etc)
- Ensuring that follow-up of incidents/changes in practice occur as necessary/appropriate

6.8 Public Health Wales Wide Leads

Some categories of incident will be forwarded to the Trust Lead(s) for that area, or those with a particular responsibility. Trust Leads are required to review the incident and provide support, guidance and advice to the incident Manager using the Datix communication and feedback section of the Datix Web Incident Form 2 (DIF2). It is therefore important that incidents are categorised / coded accurately so that follow up and support can be delivered.

6.9 Director of Communications

The Director of Communications should be informed where there could be media interest involving staff, services users and patients and adverse
publicity relating to Public Health Wales. The Communications Team will be responsible for dealing with the media in all circumstances.

7 Staff Support

All staff affected by an incident will receive support from their Manager. It is the responsibility of the Manager to ensure that a debriefing meeting is offered following a serious incident. During the debriefing process the Manager must ensure that all staff are aware of how to seek additional support. The debrief meetings should be documented on the DIF2 form.

The following support services are available to all staff:

- Network of Staff Support Ltd (NOSS)
- Workplace Options
- Occupational Health
- Trade Union
- Dignity at Work Advisors (contact HR for details)
- HR

The lead investigator / team cannot combine their role with supporting the staff involved in the incident.

8 No Blame Culture

Public Health Wales recognises that most incidents occur because of problems within systems and not individuals. The aim of the incident reporting and investigation procedure is not to apportion blame but rather to identify and address the underlying causes and prevent incidents recurring. It is vital that staff are confident that they can inform management when they are involved in an adverse event or have any practice concerns (see Whistle Blowing Policy). Incident reporting is the foundation of effective risk management.

Sometimes the investigation process will identify specific training and development needs for staff. Very occasionally, an event might give rise to both an incident investigation and disciplinary proceedings. It is important that staff are clear that further action involving staff, will only be taken in the event that there is evidence that the staff member is in breach of the law, conducted themselves in a seriously unprofessional manner or where there have been repeated similar incidents involving that member of staff.

Disciplinary action can only be taken in accordance with Public Health Wales’ disciplinary procedures and this process may consider evidence brought to light by an incident investigation.
9 Process for Learning and Promoting Improvements

A key requirement of the follow-up/closing the loop process and, in order to bring about real improvements, is the sharing of lessons learned arising from incidents with the staff involved and, where relevant, the wider organisation and external stakeholders.

The Board Committees support organisational learning, which is then shared locally through Divisions and throughout Public Health Wales. Action plans and risk reduction measures are managed and followed up locally within Divisions by the Divisional Director and Divisional General Managers / Business Managers. Following the conclusion of an incident, an analysis will be undertaken to extract the lessons learnt, to prevent recurrence. The Divisions are responsible for ensuring that lessons learned from analysis of incidents result in a change of practice.

Within Public Health Wales, lessons learned arising from incidents will be shared via the following routes:

**Individual**
- Reflective practice and discussions as part of staff supervision
- Policies and procedures to be made available to staff

**Team / Laboratory / Programme**
- Reviewing incidents that have occurred within the Team / Laboratory / Programme area
- Discussed at team meetings and briefings on lessons learnt.

**Divisional**
- Management Meetings to review incidents, along with reports from individual teams, laboratories, programmes
- Monitoring of progress against action plans
- Promotion of learning and best practice through Divisional structures and staff

**Trust Wide**
- Staff e-bulletin
- Service users / staff stories
- Mandatory training – incorporating learning from incidents into relevant training courses.
- Review of reports and external investigations by the following Committees and Groups
  - Quality and Safety Committee
  - Information Governance Committee
  - Risk Management Group
  - Information Governance Working Group
Where appropriate the Public Health Wales will share learning from incidents with the host organisations, stakeholders and partners.

10 Training and Communication with Staff

Each Manager will ensure that all members of their staff received sufficient training so that they can fulfil their individual responsibility, as details within this policy. Training will be provided at the induction stage via the e-learning induction programme and at mandatory training sessions on Health and Safety.

Training for the relevant staff on incident grading/investigation and root cause analysis will be provided as part of risk management training.

11 Monitoring and auditing

Public Health Wales recognises that analysis and review of incident data is essential in order to inform the process of learning and change. Whilst Divisions will regularly review information on incidents which occur locally within their Management Groups (or equivalent), central review of incident data will also be undertaken in order to:

- Identify organisational wide patterns or trends not noticeable or seen as significant from analysis of incidents occurring in one area of the organisation
- Provide additional valuable information for learning
- Assure the Quality and Safety Committee, Information Governance Committee, associated sub-Groups and the Board that risks of all kinds emerging from incidents are being identified and managed

Public Health Wales will monitor compliance with its incident reporting arrangements through:

- The quarterly review and analysis of incident data to ensure that
  - Incidents are reported by all areas and by all staff groups
  - Incident reporting rates
  - Timeliness of reporting with 2 days
  - Number of outstanding actions plans / recommendations
- The annual review of aggregate incident, complaints/concerns, claims data in order to identify problems/trends
• Review of lessons learned/action taken further to incidents in order to ensure that this is effective and the risk of recurrence is minimised

Where actions are identified from the aggregate review of incidents, complaints/concerns and claims, the Trust Quality and Safety Committee or the Information Governance Committee will be responsible for monitoring progress and for ensuring that lessons learned are shared and that changes in practice and culture occur as necessary. This will include the lead for a particular risk issue being asked to provide regular formal updates to the relevant Committee.

Directorate representatives on the Quality and Safety Committee and the Information Governance Committee will, in turn, be expected to ensure that lessons learned from the wider incident analysis report and the aggregate review of incidents, complaints and claims, are shared and action taken, as required, within their individual areas of responsibility.

12 Information Governance Statement

The Data Protection Act (1998) requires that personal information must be kept secure and appropriate security applied to prevent personal data held being accidently or deliberately compromised.

Incident Forms are confidential documents and must be treated as such at all times as they may include identifiable information of the persons involved. To comply with the Data Protection Act, it is essential that personal details entered on incident reports must be kept confidential and no person identifiable information should be incorporated within the detail and investigation area of the incident form as this information is reported externally to Datix.

Completed forms will only be available to authorised personnel associated with the incident reporting procedure. Any decision to share the contents of the Incident Form with an unauthorised person can only be taken by the Divisional Director, bearing in mind the duty to keep service user and staff information confidential.

Care should be taken when reporting to external bodies to ensure that danger of identification of participants is minimised, although it is recognised that in certain instances, there must be disclosure to specified investigators.

Access to Datix is controlled, role based, password protected and meets information governance requirements.
Appendix 1

Incident Investigation Flow Chart

1. Complete DIF 1 form and submit to Datix
2. Participate in investigation if required
3. Initiate investigation within
   - Low Risk 7 days
   - Medium Risk 5 days
   - Significant / Major 24 hours
4. Investigate Form investigation team
   - Identify root cause and contributing factors
   - Identify controls or corrective actions
5. Assign corrective actions
6. Complete investigation process within 14 days of initiation (with exception of STIs). Submit findings to Local, Divisional Management Groups and Corporate Services
7. Ensure corrective actions are completed, reviewed and evaluated.
8. Adequate investigation close incident on Datix
9. Participate in investigation if required
10. Review of incident reports and investigation

Date: 02 April 2013 | Version: v0d | Page: 17 of 52
# Incident Reporting Procedure

<table>
<thead>
<tr>
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<th>Organisational</th>
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**Purpose and Summary of Document:** This procedure sets out the process for managing, reporting, analysing and learning from incidents that arise in the course of Public Health Wales conducting its business. The aim is to ensure that all incidents are managed and analysed consistently, and effectively, within a supportive environment and that lessons are learnt in order to reduce risks for the future.

**Intended audience:** All Staff

**Interdependencies with other policies:** Incident Reporting policy, Information Governance Policy, Risk Assessment Policy, Putting Things Right Policy, Being Open Policy, Claims Management policy and procedure and Whistleblowing policy.

**Standards for Health Services in Wales:** Standard 1, Standard 22, Standard 23
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</tr>
</tbody>
</table>
Contents Page

1 INTRODUCTION ........................................................................................................ 21
2 AIMS AND OBJECTIVES ....................................................................................... 21
3 INCIDENTS ............................................................................................................. 21
4 INCIDENT REPORTING ......................................................................................... 22
5 RISK REGISTER .................................................................................................... 26
6 PRINCIPLES OF INCIDENT INVESTIGATION .................................................. 26
7 INCIDENT APPROVAL AND CLOSURE ............................................................. 27
8 SERIOUS INCIDENTS ......................................................................................... 27
9 EXTERNAL STAKEHOLDERS REQUIRING NOTIFICATION OF INCIDENTS .......... 31
10 PROCESS FOR LEARNING AND PROMOTING IMPROVEMENTS ........................ 33
11 INFORMATION GOVERNANCE STATEMENT ............................................... 34

APPENDIX 1 INCIDENT INVESTIGATION FLOW CHART .................................... 36
APPENDIX 2 LEAD INVESTIGATION MANAGERS CONTACTS ....................... 37
APPENDIX 3 RISK MANAGEMENT MATRIX ...................................................... 39
APPENDIX 4 GUIDELINES FOR PRODUCING A STATEMENT ......................... 44

EQUALITY IMPACT ASSESSMENT (EQIA): INITIAL SCREENING FORM .......... 45

“DOING BETTER, DOING WELL” STANDARDS FOR HEALTH SERVICE IN WALES, WELSH GOVERNMENT ................................................................. 46

EQUALITY IMPACT ASSESSMENT: ACTION PLAN ........................................... 52
1 Introduction

This procedure details the process for managing, reporting, analysing and learning from incidents that arise in the course of Public Health Wales conducting its business should be read in conjunction with the Incident Reporting policy.

It is the responsibility of all employees of Public Health Wales and anyone attending Public Health Wales premises for work to provide a service, to follow this procedure and report any incidents or near misses in which they were either directly involved or have witnessed.

Public Health Wales seeks to encourage service users and other stakeholders to report incidents, to enable Public Health Wales to obtain a more complete picture of the risks that face the organisation and to improve services.

This procedure covers all incidents (both clinical and non-clinical) and near misses involving staff, service users, visitors, contractors or any others to whom Public Health Wales owes a duty of care.

2 Aims and objectives

The main aim of this procedure is to ensure that all incidents are managed and analysed consistently, and effectively, within a supportive environment and that lessons are learnt in order to reduce risks for the future.

3 Incidents

The term “incident” is used in this document to refer to any event which gives rise to, or has the potential to produce, unexpected or unwanted effects involving service users, staff, visitors on Public Health Wales premises or employed by Public Health Wales, or loss or damage to property, records or equipment which belong to the Trust or are on Trust premises. It includes both clinical and non-clinical incidents and includes accidents, death, security breaches, violence and aggressions, failures of equipment and information governance.

In this procedure, the term ‘incident’ also encompasses ‘near misses’ i.e. incidents that that did not result in harm, loss or damage, but could have.

For a definition of Serious Incidents and the process for dealing with such incidents, please refer to paragraph 8 below.
4 Incident Reporting

Public Health Wales currently uses the Datix web based system for incident reporting. The Datix Web Incident Form (DIF1) captures the detail of the incident, and the organisations and the people involved. It acts as a record of the incident and a prompt to support action planning and reporting.

Any member of staff who is involved in, witnesses or discovers an adverse incident/accident or near miss incident/accident must complete the Datix Web Incident Form (DIF1) which is available on the Public Health Wales intranet. If you are unable to locate the Datix Web Incident Form (DIF1) please contact the Corporate Support Administrator on 01495 332299 or via email at bill.turner@wales.nhs.uk. The Manager must also be informed of all incidents that occur and ensure they are followed up.

It is understood that remedial action is often likely to take priority over the completion of the Datix Web Incident Form (DIF1). However, incident should be reported as soon as possible, ideally within 24 hours but no later than 2 days after the incident. It is also just as important to report incidents where the outcome is identified at a later stage.

The reporting timescales enable timely escalation and investigation of such incidents internally but also mean that the relevant external reporting requirements can also be met.

4.1 Verbal Reporting

The verbal reporting of an incident is very important and all incidents should be reported to appropriate Manager immediately.

If an incident is reportable to an external agency, it must be reported immediately by the quickest possible means by the appropriate manager to the Corporate Services Manager and the Professional Lead for Health and Safety.

4.2 Completing the Datix Incident Reporting Form

The Datix Web Incident Form (DIF1) should be completed by the employee concerned, with assistance, where necessary, and as soon as possible after the incident has occurred (whilst events can be clearly remembered) and within the timescales for reporting as set out in the policy.

If the incident involves a member of the public or someone who is external to Public Health Wales i.e. an Independent Contractor then the employee who witnessed the incident, or to whom the incident is reported, should complete the Datix Web Incident Form (DIF1).
When completing the Datix Web Incident Form (DIF1) it is important to include as much information as possible and that a clear, sequential analysis of what failed is documented. However, person identifiable data must be excluded from the detail of the incident, but there are appropriate fields where this can be recorded, which will not be publically available.

Once the Datix Web Incident Form (DIF1) has been completed it is submitted into DATIX, the risk management software system in place within Public Health Wales. This enables the collation and analysis of information on incidents.

If the incident is a result of faulty equipment the Manager must ensure that it is taken out of use as soon as practically possible.

When the Datix Web Incident Form (DIF1) has been completed and submitted the identified Manager will receive an email notification informing them that the form has been completed. It is the responsibility of the Manager to log into the Datix Incident system and review and complete the Datix Web Incident Form 2 (DIF2) to:

- Ensure all parts of the form are completed and coded correctly and change the coding if it is incorrect
- Identify the root cause of the incident and remedial actions to prevent similar incidents from occurring
- Initiate an investigation where appropriate
- Complete the severity and risk grading using the standard matrix and investigation field.

The review should take place within 2 days of the incident being reported. This is important for ensuring the quality, accuracy and completeness of the incident reports.

Depending on the circumstances and severity of the incident, the action taken by Managers following an incident include:

- An appropriate level of investigation. The level of investigation and resulting management action/preventative measures should be related to the severity grading of the incident
- Ensuring the appropriate personnel have been informed of the incident, the investigation and action taken and that an apology is offered, as necessary/appropriate – please also refer to the organisations Putting Things Right Policy and the Being Open Policy
- Ensuring appropriate follow-up with the affected person. (Where this is a member of staff ensuring that he/she receives first aid and/or are advised to attend A&E or their GP)
• Ensuring that faulty equipment has been taken out of use and isolated pending investigation by local contractors and/or the MHRA prior to re-use
• Notifying the Corporate Services Manager and / or the Professional Lead for Health and Safety if the incident is RIDDOR reportable or if it should be reported to another external regulatory body
• Notifying the Information Governance Managers if the incident should be reported to the Information Commissioner’s Office.
• Ensuring that incident is reported to Welsh Government if required
• Feeding back to the member of staff reporting the incident
• Debriefing/counselling and supporting of staff, as necessary and appropriate
• Implementing appropriate preventative actions
• Monitoring and review of those actions to ensure they remain effective
• Providing additional information about the causes and management of an incident that can be used to learn and improve the quality and safety of services.

4.3 Incident grading

All incidents reported should be graded according to Severity. This assesses the actual impact on the affected person(s), whether service user, member of staff or visitor to Public Health Wales and assesses:

• The actual or potential consequences for the organisation
• The likelihood of recurrence

The grading of incidents will assist in establishing:

• The level of risk associated with a particular incident; and
• The level of local investigation and root cause analysis required

The principles adopted for the grading of incidents will be consistent with those used for proactive risk assessment purposes and for the grading of concerns / complaints and claims.

Incidents should be graded using Public Health Wales’ generic Risk Assessment Tool/Grading which is accessible via the Datix Web Incident Form 2 (DIF2) Investigation screen.

The level of investigation and analysis required for individual events (whether complaint, claim or incident) should be dependent upon the grading (i.e. the nature and severity of the consequences) and not whether the event is an actual or a near miss, as follows:

<table>
<thead>
<tr>
<th>Severity</th>
<th>1</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
4.3.1 Low (Green) – Risk Rating 1 - 3

Incidents graded as 'low' (green) should be managed at operational level by team / laboratory / department manager in accordance with the day-to-day operational management procedures. No formal, detailed investigation is likely to be required, although ‘closing of the loop’ and feedback to staff / service users should occur as necessary / appropriate.

4.3.2 Moderate (Yellow) – Risk Rating 4 – 6

Incidents graded as 'moderate' (yellow) should be notified to the relevant Manager. Formal investigation requirement to be considered although may not be necessary. Action / ‘closing of the loop’ and feedback to staff / service users to occur as necessary/appropriate.

4.3.3 Significant (Orange) – Risk Rating 8 – 12

Incidents graded as 'significant’ (orange) must be investigated at a senior level and an action plan developed. Action / ‘closing of the loop’ must occur plus feedback to staff / service users and lessons learned to be shared within the Division/Directorate and throughout the organisation as appropriate. Judgement to be made as to whether to escalate as a Serious Incident – this will depend on the individual circumstances of the incident.

4.3.4 Critical (Red) – Risk Rating 15 – 25

Incidents graded as 'critical' (red) must be escalated within the Division/Directorate and notified immediately to Corporate Services Manager, in accordance with the process for dealing with SIs (paragraph 8 below).

In depth investigation, full root cause analysis and a formal action plan will be required. Action / ‘closing of the loop’ must occur plus feedback to staff and lessons learned to be shared within the Division/Directorate and throughout the organisation and to relevant external stakeholders.

Serious incidents will typically be regarded, in the context of the incident grading matrix, as ‘severe’ or ‘catastrophic’ events. Other types of adverse service users events may be deemed ‘serious’ and be immediately escalated locally or to external stakeholders. An element of judgement will be required in determining this. The timeframe for completing a serious incident investigation is set by the Welsh Government following the notification of an SI.
5 Risk Register

Where appropriate, risks highlighted via the Incident Reporting System will be added to the Divisional / Trust’s Risk Register, with details of the numbers and severity of related incidents which occur informing the grading/ranking of a particular risk on the Risk Register.

- All incidents graded 6 – 14 will be recorded on the Service Area Risk Register
- All incidents graded 15 and above will be recorded on the Divisional / Trust wide Risk Register

6 Principles of Incident Investigation

Incident investigation should:

- Identify reasons for substandard performance
- Identify underlying failures in management systems
- Learn from incidents and make recommendations
- Implement improvement strategies to help prevent, or minimise recurrences thus reducing risk of harm
- Satisfy reporting requirements

The components of any investigation are:

- Collect evidence about what happened
- Assemble and consider the evidence
- Compare the finding with relevant standards, protocols or guidelines, whether national or local to establish the facts, draw conclusions about causation and make recommendations to minimise risk
- Draw up an improvement plan with prioritised actions, responsibilities, timescales and strategies for measuring the effectiveness of actions.
- If there has been a failure in duty of care for a service user the Putting Things Right Policy should be followed.

The Manager is responsible for implementing the improvement plan and tracking progress with staff responsible for each action, along with ensuring that actions have been effective.

6.1 Joint Investigations

If there is an incident involving a number of different Health Boards / organisations, a multi agency investigation may be conducted. This will
normally be led by the primary agency/organisation involved in the service user’s care or the organisation in which the incident occurred.

For investigations which are multi-agency, the final report and lessons learned will be shared with all the organisations involved.

Some incidents will require different types of investigation such as:

- Protection of Vulnerable Adults incidents
- Safeguarding Children incidents
- Information loss or breaches incidents

In some situations the investigation process may be complicated by other factors such as:

- The incident being subject to a Coroner’s Inquest
- Investigation by the HSE or other external agencies
- The incident being subject to a complaint or claim
- Staff being subject to a HR investigation relating to the incident

In any of these circumstances the Corporate Services Manager, Professional Lead for Health and Safety or the Information Governance Managers will liaise with the staff and external agencies to ensure that the correct procedures are followed.

7 Incident approval and closure

Senior Managers will undertake the final approval and closure of an incident to determine if further action is required to reduce the risk of reoccurrence and lessons learnt are disseminated. The approval process provides assurance that management are aware of the incidents that have taken place, and that the incident has been managed.

Local Managers and other relevant Managers will have access to all incident records for their service area via the Datix online reporting system.

8 Serious Incidents

There is no single definition of an SI but in general terms it is defined as: an incident that occurred in relation to NHS funded services and care resulting in one or more of:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- severe / permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life saving intervention or major surgical / medical intervention (including a
prolonged stay within ITU i.e. more than 24 hours), or will shorten life expectancy or result in prolonged pain or psychological harm

- a scenario that prevents or threatens to prevent an organisation’s ability to continue to deliver health care services, for example significant disruption to services due to failure of an IM&T system, actual or potential loss or damage to property, reputation or the environment
- any death as a direct result of a healthcare associated infection (D&V, C.Diff, MRSA etc).
- transmission of infectious diseases
- an allegation or actual abuse including sexual, physical or psychological
- self harm injuries categorised as severe
- the core set of “never events”
- data loss and information security

It should be noted that this list is not exhaustive and an element of judgement will be required in determining what should be reported. Divisions are responsible for identifying SI’s specific to their services.

In some cases an incident may not result in direct harm to a patient(s), but may impact on service provision or organisation reputation, including adverse media coverage. In such cases a ‘no surprise’ notification should be submitted within 24 hours of the incident occurring.

### 8.1 Reporting Serious Incidents

SIs must be reported to the Welsh Government within 24 hours using the SI Notification Form. It is important to remember that the reporting of SIs to the Welsh Government and National Reporting and Learning Systems (NRLS) does not exclude the requirement to report to other bodies, e.g. HIW, HSE, Information Commissioners Office (ICO), Police, Coroner, as appropriate and as required by each individual body.

In the first instance an SI must be referred immediately to the appropriate Divisional Director and/ or their Deputy, and the Corporate Services Manager or the Director of Planning and Performance in her absence.

The Divisional Director / Deputy Director is responsible for:

- approving the SI notification form prior to forwarding to an Executive Director for signature
- nominating a responsible person(s) to undertake an investigation as necessary
- agreeing terms of reference for a comprehensive investigation
- informing the Chief Executive, relevant Executive Director, Director of Communications and Corporate Services Manager.
All completed forms should be forwarded to the Corporate Services Manager who, if required, will also provide advice on their completion. Following approval and sign off by an Executive Director of the SI notification, the Corporate Services Manager will email a password protected copy of the form to the Welsh Government’s Quality and Safety Division at: ImprovingPatientSafety@wales.GSI.gov.uk

The SI should also be reported on the Datix reporting system as soon as it occurs by the Manager for the service where the incident occurred.

Early consideration should also be given to provision of information and support to patients, relatives and staff involved in the incident, in line with the ‘Being Open Policy’ and Putting Things Right Policy.

If the incident is a potential adult or child safeguarding concern, the ‘Safeguarding Policy’ must be followed and the Named Nurse for Safeguarding informed.

If there is potential that the SI may attract media attention, there should be no delay in submitting either the ‘No Surprise’ or SI ‘Notification’ form to the Corporate Services Manager for onward transmission to the Welsh Government.

The Director of Communications should also be notified. However, if this occurs out of hours (i.e. weekdays after 5pm or before 8 am or at weekends) the matter should be escalated through the recognised Communications Team on call arrangements by ringing the central office on 029 20 348755 for the details of Communications Officer on call. The on call Communications Officer will be responsible for contacting the Welsh Government’s press office and notifying the Executive Director on call.

8.2 Grading of SIs

The initial grading of a SI is undertaken by the Welsh Government on a case by case basis and this will clarify the level of investigation required and the monitoring approach by the Government.

Grade 0
Concerns currently and commonly referred to as a ‘no surprise’ and/or where it is initially unclear whether a serious incident has occurred will be graded 0. If further information is not received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with them is required.

If following initial notification it becomes clear that the issue is an SI then further information should be sent to the Welsh Government and the grading will be reviewed.
**Grade 1**
It is expected that a comprehensive investigation (RCA level 2 investigation) should be completed within **3 calendar months**. The investigation report and action plan will be reviewed by Public Health Wales’ Quality and Safety Committee. The report and action plan will also be sent to the Welsh Government for review and confirmation that they are content with the actions undertaken prior to closing the incident.

If an incident investigation cannot be completed within the timescale agreed the Corporate Services Manager will seek an extension to the timescales from the Welsh Government.

**Grade 2**
This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by HIW or other regulatory bodies.

### 8.3 Completion of the Investigation - SIs

The SI investigation report will be signed off by the Investigation Officer and Divisional Director.

The SI investigation report will be reviewed by the relevant Executive Director and Director of Planning and Performance in his role as the PTR Responsible Officer and any other appropriate person. All SI reports will be forwarded to the Quality and Safety Committee, the Welsh Government and relevant Health Board.

A letter should also be forwarded to the patient involved in the SI, detailing:

- a summary of the matters investigated
- a description of the investigation undertaken
- an invitation to meet to discuss the incident and outcome
- the contact details of the Public Services Ombudsman for Wales
- the remedial action taken and / or being implemented

The draft letter should be forwarded to the Director of Planning and Performance (PTR Responsible Officer) and the Corporate Services Manager (SIM), prior to forwarding to the Chief Executive for signature.

### 8.4 Closure and dissemination of learning from SIs

On completion of the investigation a closure form should be completed and forwarded to the Divisional Director for approval. Approved SI closure forms will be signed off by an Executive Director and emailed to the Welsh Government by the Corporate Services Manager.
Organisational learning from SIs must be recorded within the investigation report and on the closure form submitted to the Welsh Government. Divisions will be responsible for disseminating lessons learnt.

9 External stakeholders requiring notification of incidents

Public Health Wales will ensure that, where relevant, the following external stakeholders are informed of and, where appropriate, involved in the investigation of adverse incidents/accidents which occur. Unless, otherwise stated within each relevant section, reporting to the external stakeholders listed below will be undertaken corporately.

9.1 Health & Safety Executive (HSE)

In line with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents, Public Health Wales has a statutory responsibility to report certain incidents / accidents which occur during the course of work activity to the HSE. Failure to comply with this may lead to Public Health Wales being prosecuted for a breach of regulations and further enforcement action being taken.

RIDDOR incidents are reported to the HSE by the Corporate Services Manager or the Professional Lead for Health and Safety following notification or receipt Datix Web Incident Form (DIF1). Details of the incident need to be reported to the HSE within 10 days of the incident. Early notification of accidents/incidents means that Public Health Wales is able to comply with this requirement. Liability lies with the “responsible person” i.e. the person in charge of the work activity in that area in line with managers’ responsibilities.

All RIDDOR reports and supporting information will be uploaded into Datix and linked to the relevant incident.

There may be other instances where the HSE may need to be notified of incidents which occur. This will depend on the circumstances and severity of the incident. The Professional Lead for Health and Safety will advise whether it is necessary to inform the HSE and whether the area involved needs to be isolated until a HSE Inspector has visited.

9.2 Serious Incidents – Welsh Government

Serious Incidents must be reported to the Welsh Government within 24 hours of the incident occurring. (Please refer to paragraph 8.1 above.)
9.3 **National Patient Safety Agency (NPSA)**

All NHS organisations are required to report all ‘patient safety’ incidents to the National Reporting and Learning System (NRLS). This is undertaken via the Datix Risk Management system. The information submitted to the NPSA contains no staff or patients identifiers.

9.4 **The Medicines and Healthcare Products Regulatory Agency (MHRA)**

The MHRA is the Executive Agency of the Department of Health responsible for protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely.

Public Health Wales is required to report to the MHRA, any adverse incident involving a medical device, especially if the incident has led to or, were it to occur again, could lead to death or serious injury, medical or surgical intervention (including implant revision), hospitalisation or unreliable test results.

Electronic reporting using the online form on the MHRA website is the preferred method. Reports may however also be sent by e-mail, fax or post. Report forms may be downloaded / printed from the MHRA website.

Reports sent to the MHRA should also be forwarded to the Corporate Services Manager and the Professional Lead for Health and Safety.

9.5 **Shared Services Partnership - Facilities**

The following incidents, which involve defects and failures of buildings, plant, nonmedical equipment or fire protection installations and equipment, will be reported to the Shared Services Partnership - Facilities, via the Facilities Manager, in accordance with the NHS Estates Procedure for the Reporting of Defects and Failures involving non-medical devices:

- Any event, which gives rise to or has the potential for unexpected or unwanted effects involving the safety of service users, staff and others;
- Incidents that arise through incorrect use, inappropriate modifications or adjustments, or inadequate servicing and maintenance procedures;
- Deficiencies in the technical or economical performance of equipment;
- Any defects in product, instructions, identified by Health & Safety Inspectors or Local Authority Inspectors;
- Failure in critical services (electricity, water, steam, gas, communication etc.) that would affect the safety of service users and others.
9.6  Counter Fraud

The Counter Fraud has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption.

9.7  Other

Depending on the circumstances and severity of the incident, other external stakeholders may need to be notified, and in some instances involved in the investigation, of incidents which occur. (This is a decision which would normally be taken corporately, as part of the response to the incident.) These include:

- MPs / AMs
- Other hospitals / Health Boards
- Legal representatives
- Police
- Coroner
- GMC / GNC
- Emergency Planning Officer – Local Authorities
- Local Authority Health Scrutiny Lead(s)
- Social Services (as appropriate)
- Emergency Services (if appropriate)
- Ombudsman
- Information Commissioner Office (ICO)
- Deanery
- Recognised Trade Union Representatives

10  Process for learning and promoting improvements

A key requirement of the follow-up/closing the loop process and, in order to bring about real improvements, is the sharing of lessons learned arising from incidents with the staff involved and, where relevant, the wider organisation and external stakeholders.

The Board Committees support organisational learning, which is then shared locally through Divisions and throughout Public Health Wales. Action plans and risk reduction measures are managed and followed up locally within Divisions by the Divisional Director and Divisional General Managers / Business Managers. Following the conclusion of an incident, an analysis will be undertaken to extract the lessons learnt, to prevent recurrence. The Divisions are responsible for ensuring that lessons learned from analysis of incidents result in a change of practice.

Within Public Health Wales, lessons learned arising from incidents will be shared via the following routes:
Individual
- Reflective practice
- Discussed as part of staff supervision
- Policies and procedures to be made available to staff

Team / Laboratory / Programme
- Reviewing incidents that have occurred within the Team / Laboratory / Programme area
- Team / Laboratory / Programme briefings on lessons learnt
- Discussed at team meetings

Divisional
- Management Meetings to review incidents, along with reports from individual teams, laboratories, programmes
- Monitoring of progress against action plans
- Promotion of learning and best practice through Divisional structures and staff

Trust Wide
- Staff e-bulletin
- Service users / staff stories
- Mandatory training – incorporating learning from incidents into relevant training courses.
- Review of reports and external investigations by the following Committees and Groups
  - Quality and Safety Committee
  - Information Governance Committee
  - Risk Management Group
  - Information Governance Working Group
  - Health and Safety Group
  - Infection Control Group
  - SI report to the Quality and Safety Committee and Trust Board
- Dissemination of safety alerts

Where appropriate the Public Health Wales will share learning from incidents with the host organisations, stakeholders and partners.

11 Information Governance Statement

Incident Forms are confidential documents and may include identifiable information of the persons involved and from a business aspect. To comply with the Data Protection Act 1998 (DPA), it is essential that personal details entered on incident reports are kept confidential and no person identifiable information should be incorporated within the detail and investigation area of the incident form as this information is reported externally to Datix.
Completed forms will only be available to authorised personnel associated with the incident reporting procedure. Any decision to share the contents of the Incident Form with an unauthorised person can only be taken by the Divisional Director, bearing in mind the duty to keep service user and staff information confidential.

If reports of incidents are tabled at meetings to disseminate ‘lessons learnt,’ staff are reminded that the contents are to be treated confidentially.

Care should be taken when reporting to external bodies to ensure that danger of identification of participants is minimised, although it is recognised that in certain instances, there must be disclosure to specified investigators.
Appendix 1

Incident Investigation Flow Chart

1. Individual Reporting
   - Complete DIF 1 form and submit to Datix
2. Manager
   - Receive notification of incident
   - Assess risk classification to determine investigation
   - Participate in investigation if required
3. Divisional Director/General Manager
4. Corporate Services Manager and Trust Wide Leads
5. QSS Committee
   - Notify regulatory authority if required
6. Participate in investigation if required
7. Initiate investigation within
   - Low Risk 7 days
   - Medium Risk 5 days
   - Significant/Major 24 hours
8. INVESTIGATION
   - Form investigation team
   - Identify root cause and contributing factors
   - Identify controls or corrective actions
9. Assign corrective actions
10. Complete investigation process within 14 days of initiation (with exception of SIs). Submit findings to Local, Divisional Management Groups and Corporate Services
11. Ensure corrective actions are completed, reviewed and evaluated.
12. Adequate investigation—close incident on Datix
13. Review of incident reports and investigation
## Appendix 2  Lead Investigation Managers Contacts

<table>
<thead>
<tr>
<th>Position</th>
<th>Area of concern</th>
<th>Address</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Services Manager (Risk Management)</td>
<td>Organisational Wide</td>
<td>Mamhilad House Mamhilad Park Estate, Pontypool, Gwent NP4 YP</td>
<td>01495 332215</td>
</tr>
<tr>
<td>Information Governance Manager</td>
<td>Information Governance</td>
<td>Unit 1 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff CF15 7QZ</td>
<td>01443 824184</td>
</tr>
<tr>
<td>Corporate Services Manager</td>
<td>Corporate</td>
<td>Unit 1 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff CF15 7QZ</td>
<td>01443 846475</td>
</tr>
<tr>
<td>Risk, Health and Safety Manager</td>
<td>Screening Division</td>
<td>16 Cathedral Road, Cardiff CF11 9LJ</td>
<td>02920 787857</td>
</tr>
<tr>
<td>Programme Lead</td>
<td>Cervical Screening Programme</td>
<td>Screening Division Head Office 18 Cathedral Road Cardiff. CF11 9LJ</td>
<td>02920 787846</td>
</tr>
<tr>
<td>Programme Lead</td>
<td>Bowel Screening Programme</td>
<td>Bowel Screening Centre Unit 6, Green Meadow Llantrisant. CF72 8XT</td>
<td>02920 787824</td>
</tr>
<tr>
<td>Head of Programme</td>
<td>Breast Test Wales</td>
<td>Screening Division Head Office 18 Cathedral Road Cardiff. CF11 9LJ</td>
<td>02920 787837</td>
</tr>
<tr>
<td>All Wales Screening Coordinator</td>
<td>Antenatal Screening Wales</td>
<td>Screening Division Head Office 18 Cathedral Road Cardiff. CF11 9LJ</td>
<td>01978 727006</td>
</tr>
<tr>
<td>Associate Director</td>
<td>Newborn Hearing Screening Wales</td>
<td>Wrexham Child Health Centre Wrexham Maelor Hospital Wrexham. LL13 7ZA</td>
<td>01970 635813</td>
</tr>
<tr>
<td>Laboratory Director</td>
<td>Microbiology Aberystwyth</td>
<td>Public Health Wales Microbiology Bronglais General Hospital Caradog Road, Aberystwyth</td>
<td>01495 332215</td>
</tr>
<tr>
<td>Role</td>
<td>Division</td>
<td>Address</td>
<td>Phone</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Head of Administration</td>
<td>Screening Division</td>
<td>St David’s Park, Jobswell Road, Carmarthen SA31 3YH</td>
<td>01267 225264</td>
</tr>
<tr>
<td>Laboratory Director</td>
<td>Microbiology Bangor</td>
<td>Public Health Wales Microbiology Ysbyty Gwynedd Bangor, LL57 2PW</td>
<td>01248 384367</td>
</tr>
<tr>
<td>Laboratory Director / Laboratory Manager</td>
<td>Microbiology Cardiff (University Hospital of Wales &amp; Llandough)</td>
<td>University Hospital of Wales Heath Park, Cardiff CF14 4XW</td>
<td>02920 744515</td>
</tr>
<tr>
<td>Laboratory Director</td>
<td>Microbiology Carmarthenshire (Carmarthen &amp; Llanelli)</td>
<td>West Wales General Hospital Glangwili, Carmarthen</td>
<td>01267 237271/236964</td>
</tr>
<tr>
<td>Laboratory Director</td>
<td>Microbiology Rhyl</td>
<td>Public Health Wales Microbiology Glen Clwyd District General Hospital Rhyl LL18 5UJ</td>
<td>01745 583737</td>
</tr>
<tr>
<td>Laboratory Director / Laboratory Manager</td>
<td>Microbiology Abertawe Bro Morgannwg (Swansea and Bridgend)</td>
<td>Singleton Hospital, Sgeti Swansea  SA2 8QA</td>
<td>01792 285055</td>
</tr>
<tr>
<td>Director</td>
<td>Communicable Disease Surveillance Centre</td>
<td>Temple of Peace and Health Cathays Park, Cardiff CF10 3NW</td>
<td>02920 402471</td>
</tr>
<tr>
<td>General Manager</td>
<td>Microbiology &amp; Health Protection Division</td>
<td>Temple of Peace and Health Cathays Park, Cardiff CF10 3NW</td>
<td>02920 402530</td>
</tr>
<tr>
<td>Quality Manager</td>
<td>Microbiology Division</td>
<td>Public Health Wales Microbiology Singleton Hospital, Sgeti Swansea  SA2 8QA</td>
<td></td>
</tr>
<tr>
<td>Microbiology H&amp;S Advisor</td>
<td>Microbiology Health and Safety</td>
<td>Public Health Wales Microbiology Heath Park, Cardiff CF14 4XW</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3  

Risk Management Matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

<table>
<thead>
<tr>
<th>Consequence score (severity levels) and examples of descriptors</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains</strong></td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>Major</td>
<td>Catastrophic</td>
</tr>
<tr>
<td>Impact on the safety of patients, staff or public (physical/psychological harm)</td>
<td>Minimal injury requiring no/minimal intervention or treatment.</td>
<td>Minor injury or illness, requiring minor intervention</td>
<td>Moderate injury requiring professional intervention</td>
<td>Major injury leading to long-term incapacity/disability</td>
<td>Incident leading to death</td>
</tr>
<tr>
<td>No time off work</td>
<td>No time off work for &gt;3 days</td>
<td>Requiring time off work for 4-14 days</td>
<td>Requiring time off work for &gt;14 days</td>
<td>Multiple permanent injuries or irreversible health effects</td>
<td></td>
</tr>
<tr>
<td>Increase in length of hospital stay by 1-3 days</td>
<td>Increase in length of hospital stay by 4-15 days</td>
<td>Increase in length of hospital stay by &gt;15 days</td>
<td>An event which impacts on a large number of patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RIDDOR/agency reportable incident</td>
<td>Mismanagement of patient care with long-term effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An event which impacts on a small number of patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality/ complaints/ audit</td>
<td>Peripheral element of treatment or service suboptimal</td>
<td>Overall treatment or service suboptimal</td>
<td>Treatment or service has significantly reduced effectiveness</td>
<td>Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>Totally unacceptable level or quality of treatment/service</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Informal complaint/inquiry</td>
<td>Formal complaint (stage 1)</td>
<td>Formal complaint (stage 2) complaint</td>
<td>Multiple complaints/ independent review</td>
<td>Gross failure of patient safety if findings not acted on</td>
<td></td>
</tr>
<tr>
<td>Local resolution</td>
<td>Local resolution (with potential to go to independent review)</td>
<td>Low performance rating</td>
<td>Inquest/ombudsman inquiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single failure to meet internal standards</td>
<td>Repeated failure to meet internal standards</td>
<td>Critical report</td>
<td>Gross failure to meet national standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor implications for patient safety if unresolved</td>
<td>Major patient safety implications if findings are not acted on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced performance rating if unresolved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human resources/ organisational development/staffing/ competence</td>
<td>Short-term low staffing level that temporarily reduces service quality (&lt; 1 day)</td>
<td>Low staffing level that reduces the service quality</td>
<td>Late delivery of key objective/ service due to lack of staff</td>
<td>Uncertain delivery of key objective/service due to lack of staff</td>
<td>Non-delivery of key objective/service due to lack of staff</td>
</tr>
<tr>
<td></td>
<td>Unsafe staffing level or competence (&gt;1 day)</td>
<td>Unsafe staffing level or competence (&gt;5 days)</td>
<td>Ongoing unsafe staffing levels or competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low staff morale</td>
<td>Loss of key staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of several key staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td>Poor staff attendance for mandatory/key training</td>
<td>Very low staff morale</td>
<td>No staff attending mandatory/key training on an ongoing basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td>No or minimal impact or breach of guidance/statutory duty</td>
<td>Breech of statutory legislation</td>
<td>Single breech in statutory duty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td>Reduced performance rating if unresolved</td>
<td>Challenging external recommendations/improvement notice</td>
<td>Multiple breeches in statutory duty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td></td>
<td></td>
<td>Improvement notices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory duty/inspections</td>
<td></td>
<td></td>
<td>Complete systems change required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse publicity/reputation</td>
<td>Rumours</td>
<td>Local media coverage – short term reduction in public confidence</td>
<td>Local media coverage – long term reduction in public confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse publicity/reputation</td>
<td>Potential for public concern</td>
<td>National media coverage with &lt;3 days service well below reasonable public expectation</td>
<td>National media coverage with &gt;3 days service well below reasonable public expectation. MP concerned (questions in the House)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse publicity/reputation</td>
<td></td>
<td></td>
<td>Total loss of public confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business objectives/projects</td>
<td>Insignificant cost increase/schedule slippage</td>
<td>5–10 per cent over project budget</td>
<td>Non-compliance with national 10–25 per cent over project budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business objectives/projects</td>
<td></td>
<td></td>
<td>Incident leading &gt;25 per cent over project budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business objectives/projects</td>
<td></td>
<td></td>
<td>Schedule slippage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date: 02 April 2013</td>
<td>Version: 0d</td>
<td>Page: 41</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Key objectives not met

<table>
<thead>
<tr>
<th>Finance including claims</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Small loss Risk of claim remote</td>
<td>Loss of 0.1–0.25 per cent of budget</td>
<td>Loss of 0.25–0.5 per cent of budget</td>
<td>Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget</td>
<td>Non-delivery of key objective/Loss of &gt;1 per cent of budget</td>
</tr>
<tr>
<td>Claim less than £10,000</td>
<td>Claim(s) between £10,000 and £100,000</td>
<td>Claim(s) between £100,000 and £1 million</td>
<td>Failure to meet specification/slippage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service/business interruption</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss/interruption of &gt;1 hour</td>
<td>Loss/interruption of &gt;8 hours</td>
<td>Loss/interruption of &gt;1 day</td>
<td>Loss/interruption of &gt;1 week</td>
<td>Permanent loss of service or facility</td>
</tr>
<tr>
<td>Environmental impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimal or no impact on the environment</td>
<td>Minor impact on environment</td>
<td>Moderate impact on environment</td>
<td>Major impact on environment</td>
<td>Catastrophic impact on environment</td>
</tr>
</tbody>
</table>

### Table 2 Likelihood score (L)

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>May only occur in exceptional circumstances</td>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
<td>Will probably happen/recur but it is not a persisting issue</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
</tbody>
</table>
### Scoring Table

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>5 Critical</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 Significant</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Low Risk: 1 - 3
Moderate Risk: 4 - 6
Significant: 8 - 12
Critical: 15 - 25
Appendix 4 Guidelines for producing a statement

Purpose

- To tell a third party about events in the author participated
- To tell a third party about events which the author witnessed.

When writing a statement ensure that:

- The statement is factual
- It includes all relevant information
- Sufficient detail about the incident is provided
- Words or phrase of a technical / clinical nature are explained
- It is accurate and concise
- It is legible if handwritten
- It has been checked for errors if typed from hand written
- A copy is retained.

Do not

- Exaggerate
- Minimise events
- Include hearsay
- Use cliché
- Use abbreviations
- Use ambiguous terms
- Use jargon
- Sign the statement unless you are 100% satisfied with it.

However, when a statement is produced (typed/written) it will be reproduced onto headed paper. Individuals will be given an opportunity to check this prior to signing and dating.
Equality Impact Assessment (EQIA): Initial Screening Form

Name of the policy, service or project: Incident policy and procedure
(Referred to just as ‘policy/service’ herein)

Service Area: Organisation Wide

a. Preparation

The work on this section should be done in advance and be used as part of your EQIA. Please attach examples of available monitoring information, research and consultation reports.

1. Do you have monitoring data available on the number of people who are using or impacted upon by your policy/service?
   
   - Number of people with disabilities
   - Black and minority ethnic communities
   - Women and men
   - New areas, such as sexual orientation, religion and non belief and age
   - Welsh Language

   Partial  Yes  No
   √  √

   If you have answered ‘Yes’ to the above questions your monitoring data should be compared to the current available census data to see whether a proportionate number of people are taking up your service / utilising your policy.

2. If monitoring has NOT been undertaken, will this be done in future?
   (e.g statutory duty under the Race Relations Amendment Act, 2000)

   Yes  No
   ✗  ☐

   If so, specify the arrangements you intend to make; if not, please give a reason for your decision:
Public Health Wales uses ESR to collect, monitor and analyse this data. Ongoing implementation of ESR and improvements to the way in which data is collected through the system will make it easier to monitor this information.

3. **If you are aware of any relevant local or national equality or diversity-related consultation, research, or good practice guidance, then please list (please list specific research etc related to this area for information)**
   “Doing Better, Doing Well” Standards for Health Service in Wales, Welsh Government
   Yes  No

b. **Your policy, service or project**

1. **What is it’s main purpose?**
   The policy and procedure aim to prevent, reduce and control risks in order to protect individuals and the organisation from unintended harm, damage or loss. The procedure establishes a process for dealing with incidents from occurrence, to investigation and closure. This ensures that all incidents are reported, managed and analysed in a consistent way.

2. **List the areas of activity/impact of the policy, e.g. the recruitment strategy might have advertising, interviewing, short listing etc. as activity areas.**
   The policy will impact on all areas of work within Public Health Wales.

3. **Who are the main beneficiaries of the policy?**
   All Staff, contractors, visitors and service users.

4. **Is the policy divisional or Trust - wide?**
   Trust Wide
   Div  TW
5. In your view, does the policy assist clients or staff in meeting their most basic needs, i.e. improved health, fair recruitment and working practices? Yes No

6. What number of people may be affected by the policy? All Staff, Visitors and Service Users.

7. Are you expecting to make any changes to the policy during the next year? Yes No

### c. The Impact

1. Complete the following tables using ticks.

   Consider the information gathered in Section (a) of this Screening Form, comparing monitoring information with census data, and considering any earlier research or consultations. You could also look at section _ of the EQIA Guidance Notes for areas of possible effect:
   - Where you think that the policy could have a negative impact on any of the equality target groups, i.e. it could disadvantage them.
   - Where you think that the policy could have a positive impact on any of the equality target groups or contribute to promoting equality, equal opportunities, or improving relations within equality target groups.

   **a. Does the policy affect men and women in different ways, e.g. flexible working arrangements might have a positive impact on women with caring responsibilities**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td>☑</td>
<td>☑</td>
<td>The policy does not have an impact in this area. The policy promotes a safe working environment for all staff, visitors and service users and does not affect men and women in different ways.</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>☑</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td>☑</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>
Do people from different black and minority ethnic communities use the Trust’s services differently, e.g. will women from certain minority communities use the Trust’s screening service or be aware of services on offer? Is health promotion information made available via outreach work to Gypsies and Travellers. Or if an internal policy, what impact could the policy have in relation to staff, via areas such as recruitment and selection, training, secondments and other working conditions?

<table>
<thead>
<tr>
<th>Race</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td>This policy aims to prevent, reduce and control risks in order to protect individuals and the organisation from unintended harm, damage or loss. It therefore has a neutral impact in this area.</td>
</tr>
<tr>
<td>Black or Black-British</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Chinese and other</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>White (including Irish)</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

How will the policy impact on people with disabilities, e.g. if information is not made available in large print or alternative formats, access to such services might be denied to people with a visual impairment or learning disability and result in poor health.

<table>
<thead>
<tr>
<th>Disability</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visually impaired</td>
<td></td>
<td></td>
<td>☑</td>
<td>This policy aims to ensure a consistent approach to the way in which incidents are reported and managed.</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td></td>
<td></td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Physically disabled</td>
<td></td>
<td></td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td></td>
<td></td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Mental health condition or long term illness/condition</td>
<td></td>
<td></td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>
d. Does sexual orientation impact on the services that the Trust provides, e.g. cervical screening available to lesbians, or sexual health information available covering all areas of sexuality. Or if an internal policy, what impact could the policy have in relation to staff, via areas such as recruitment and selection, training, secondments and other working conditions?

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

This policy aims to ensure a consistent approach to the way in which incidents are reported and managed.

If the negative impact is potentially discriminatory and not intended and/or of high impact, you must complete a full Equality Impact Assessment.

e. Does religious belief or non-belief impact on the services that the Trust provides, e.g. sensitivities regarding death and burial requirements or provision of contemplation or prayer rooms, blood donor’s. Or if an internal policy, what impact could the policy have in relation to staff, via areas such as recruitment and selection, training, secondments and other working conditions?

<table>
<thead>
<tr>
<th>Religion</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Sikh</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Judaism</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Pagan</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Atheist</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

Religious belief will not have impact on the implementation of this policy.
f How will the policy impact on services provided to different age group’s, such as information on youth sexual health or age restrictions on screening services.

<table>
<thead>
<tr>
<th>Age</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td></td>
<td></td>
<td></td>
<td>Age will not impact on the implementation of this policy,</td>
</tr>
<tr>
<td>5-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>25-50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

g Does this policy treat the English and Welsh languages on the basis of equality as specified in the Trust’s Welsh Language Scheme i.e. Can a welsh speaker and an English speaker expect the same level of service?

<table>
<thead>
<tr>
<th>Welsh language</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welsh</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilingual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is potentially discriminatory and not intended and/or of high impact, you must compete a full Equality Impact Assessment.

2. **a Could you minimise or remove any negative impact that is of low significance?**

Yes  No

<table>
<thead>
<tr>
<th>Gender</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Welsh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: 02 April 2013  Version: 0d  Page: 50
Could you improve the positive impact?  
Explain how

<table>
<thead>
<tr>
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<tbody>
<tr>
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</tr>
<tr>
<td>Disability:</td>
<td>Welsh</td>
</tr>
<tr>
<td>Sex/ Orien:</td>
<td></td>
</tr>
</tbody>
</table>

3. If there is no evidence that the policy promotes equality, equal opportunities, or improved relations, could it be adapted so that it does?  
Explain how

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4. As a result of this initial screening, what is the impact of your policy on the equality target groups?  
Low  | Medium  | High
|     |         |

5. Is progression to a full impact assessment required?  
Yes  | No
|     |

Please keep a copy on record to which the public could have full access.

Signed (Lead) Gay Reynolds  
Signed (Completing)       

Date: 02 April 2013  
Version: 0d  
Page: 51
Equality Impact Assessment: Action Plan

Please list below any recommendations for action that you plan to take as a result of this impact assessment.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action Required</th>
<th>Lead Officer</th>
<th>Time-scale</th>
<th>Resource implications</th>
<th>Comments</th>
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</thead>
<tbody>
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Date: 02 April 2013    Version: 0d    Page: 52