Incident Policy and Standard Operating Procedure

Approved

Authorship:	Patient Safety Lead
Committee Approved:	Quality Group
Approved date:	22/03/ 2017
Review Date:	March 2020
Equality Impact Assessment	Screening Completed
Sustainability Impact Assessment	Completed
Target Audience:	All employees, lay members, committee and sub-committee members of the group and members of the governing body and its committees.
Policy Reference No:	

Version Number: **1.0**

The intranet version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will Be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
1	NLCCG	New Policy	Quality Group 22/03/ 2017	March 2017

Contents

1. INTRODUCTION

The Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients and their carer's, the public, staff, stakeholders and use of public resources.

In order to provide clear and consistent guidance, CCG will develop documents to fulfil all statutory, organisational and best practice requirements. The organisation has a responsibility for managing incidents to ensure the quality of the services it commissions is safe and of a high standard.

The CCG has a responsibility to ensure their contractors have effective systems in place to identify and manage incidents and risks and support them in their development where necessary.

In our duties as a CCG we are required to act as a conduit for information about such risks and incidents and to ensure that the learning (and the opportunities for risk reduction) from them is not lost within the CCG or the wider NHS.

This policy sets out the CCG's approach to the management of incidents in fulfilment of its strategic objectives and statutory obligations.

2. PURPOSE & DEFINITIONS

The purpose of the policy is to outline the arrangements for identifying, managing, responding to and learning from incidents reported by/into North Lincolnshire Clinical Commissioning Group (NLCCG).

The reporting of all incidents, prevented incidents (near misses) is designed to ensure the following:

- A culture of openness in reporting incidents or prevented incidents (near misses)
- Prompt and precise gathering of information
- Prompt communication with staff and where appropriate the media
- Minimisation of distress to those affected by an incident
- Identification of patterns and trends in the occurrence of incidents and prevented incidents (near-misses)
- Minimise, so far as is reasonably practicable, future risk by taking prompt and appropriate preventive action and on-going monitoring
- Early warning of potential litigation and cost impact
- Local managers are able to review local safety procedures
- Fulfilment of the CCG's legal duties under statutory regulations including RIDDOR 1995, The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999

DEFINITIONS

Incident/Accident
An unexpected or unplanned event that caused harm, or had the potential to cause harm, to a patient, member of staff, visitor, contractor or the CCG.

- **Personal accident.** Personal accidents are accidental incidents which affect and/or involve a person or persons and resulted or could have resulted in injury.

- **Violence, abuse, harassment.** Incidents which cannot be reasonably said to be accidental in motive and include physical assaults by any person, deliberate self-harm, aggressive incidents, and other incidents involving verbal abuse, sexual or racial harassment, or intimidation or threatening behaviour.

- **Ill health, work or environmental related incidents.** Illness which is related to work or the environment and could include hospital acquired infections, industrial asthma and eczema. Unsafe environments, flooding, lighting/power/heating failure leading to of loss of services.

- **Fire Incident.** Any incident which involves smoke, fire, suspected smoke or fire, or fire alarm whether it be actual or suspected.

- **Security Incident.** A security incident is one in which there is fraud, theft, deception, criminal damage, car crime, amongst other things involving staff, visitors to the CCG and its property as well as encompassing all CCG property.

- **Clinical incident.** A clinical incident is one which arises in the context of the duty of care owed to patients by members of the healthcare professions, or consequences on decisions or judgments made by those professions in their professional capacity or relevant work.

Near Miss
An event that has the potential to cause harm or was prevented from causing harm to one or more individuals, damage to property, a security breach or confidentiality breach.

Potential Risk
An unexpected or unplanned event that caused harm or had the potential to cause harm to a member of staff, visitor or contractor and the situation/environment continues to pose a risk.

Serious Incidents
A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, visitors or members of the public

- Serious harm to one or more patients or where the outcome requires lifesaving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Work related death
- Allegations of abuse
- High profile media attention or public concerns about the organisation
- Serious security related incidents resulting in loss or damage to a property or assets of the NHS preventing the CCG from carrying out its duties

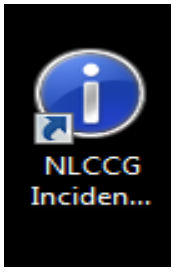
3. POLICY STATEMENT

Making services safe for service users and staff is fundamental to the delivery of high quality services.

As an organisation it is essential that the Clinical Commissioning Group has a good system in place for reporting and managing incidents. The CCG recognises the importance of reporting all incidents and near misses as part of its governance and risk management strategy.

This policy applies to all employees of the CCG, inclusive of those on a temporary contract, locums, lay members, contracted staff, providers contracted to complete a service on behalf of the CCG, practice staff (including GP's) working on CCG business.

The CCG's incident reporting system is an electronic application, named the NLCCG Incident Application.



Incidents can be reported directly onto the NLCCG Incident Application or via email to NLCCG.Incidents@nhs.net Those reported via email are entered into the NLCCG application by the Quality Team on behalf of the reporter.

Upon entering the incident or near miss onto the application a required field that must be completed is whether the incident requires investigation. All members of the Incident Group have the authority to overturn the instruction of an investigation to require should a rationale for this be identified.

If an investigation is indicated the incident record is forwarded to the Line Manager of the Service Area/or to the designated Professional within the Provider organisation who is responsible for ensuring a robust investigation occurs.

All incidents and near misses which occur whilst in the employment/on the premises of NLCCG property must be recorded on the incident application.

A commitment to fair and open culture
An incident, however serious, is rarely caused wilfully. It is not, in itself, evidence of carelessness, neglect or a failure to carry out a duty of care. Errors are often caused by a number of factors including; process problems; human error; individual behaviour and lack of knowledge or skills. Learning from such incidents can only take place when they are reported and investigated in a positive, open and structured way.

Determining safe practice is an important part of successful risk management. The drive for incident reporting is learning from them and to establish a fair and open culture which enables safe practice throughout the organisation. This will enable the CCG to identify trends and take positive action to prevent the error or adverse incident from happening again.

To promote a fair and open culture and encourage the reporting of incidents, the CCG will take a non-punitive approach to those incidents it investigates unless there is evidence of gross professional or gross personal misconduct; repeated breaches of acceptable behaviour or protocol; or an incident that results in a police investigation.

The CCG have an open approach when staff, patients, relatives and carers have suffered harm as a result of an organisation or commissioning incident. They will be given an apology and explanation of what happened. This is NOT an admission of liability but an acknowledgement that untoward harm has occurred. It is the responsibility of the senior lead or appropriate healthcare professional to inform patients, relatives and/or carers of any adverse incident that has resulted in an untoward outcome. The CCG is responsible for ensuring the Duty of Candour is appropriately discharged within the incident process for all incidents attributed to the organisation. All incidents reported into our system which have occurred in another provider of service are the responsibility of the provider to ensure all Legislation, National and Local Policies are procedures are followed.

4. ROLES & RESPONSIBILITIES

CCG staff responsibilities
It is everyone's responsibility to comply with the Incident policy and procedure. Essentially, it is the responsibility of all staff to identify, take any proportionate immediate action that is required in response to the incident and report Incidents on the CCG incident application.

The **Accountable Officer** is ultimately responsible for ensuring compliance with the Health & Safety at Work Act 1974 and associated legislation, and that this policy is implemented and effective within North Lincolnshire Clinical Commissioning Group. The Accountable Officer is responsible for ensuring that a system and process is in place for recording, monitoring and responding to incidents within the CCG.

The **Patient Safety Lead** for North Lincolnshire Clinical Commissioning Group is responsible for writing and implementing the policy and monitoring its effectiveness. They will ensure that the policy is adhered to including the internal and external reporting arrangements.

The **Caldicott Guardian** is responsible for ensuring the protection and use of patient identifiable information, which may be used during the incident reporting process.

The **Patient Experience Manager** will ensure that any complaints arising from incidents are managed in accordance with the CCG's Complaints Policy.

The **Incident Group** will receive and review monthly incident reports to ensure that risk management issues have been addressed and to ensure that recommendations for improvements are implemented to reduce risk.

The **Information Asset Owner** (IAO) is a mandated role, and the individual appointed is responsible for ensuring that information assets are handled and managed appropriately. This means making sure that information assets are properly protected and that their value to the organisation is fully exploited.

The **Senior Information Risk Owner** (SIRO) is an Executive Director or Senior Management Board Member who will take overall ownership of the Organisation's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Annual Governance Statement in regard to information risk.

The SIRO must understand how the strategic business goals of the Organisation and how other organisations' business goals may be impacted by information risks, and how those risks may be managed. The SIRO implements and leads the Information Governance (IG) risk assessment and management processes within the Organisation and advises the Partnership Board on the effectiveness of information risk management across the Organisation.

Information Governance Lead the IG Lead works with eMBED IG Team to ensure systems are developed and implemented. The IG Lead is responsible for the co-ordination of the implementation within the CCG. The IG lead is accountable for ensuring effective management, accountability, compliance and assurance for all aspects of IG within the CCG. This role includes but is not limited to:

- developing and maintaining the currency of comprehensive and appropriate documentation that demonstrates commitment to and ownership of IG responsibilities, e.g. an overarching high level strategy document supported by corporate and/or directorate policies and procedures;
- ensuring that there is top level awareness and support for IG resourcing and implementation of improvements;
- providing direction in formulating, establishing and promoting IG policies;
- establishing working groups, if necessary, to co-ordinate the activities of staff given IG responsibilities and progress initiatives;
- ensuring annual assessments and audits of IG policies and arrangements are carried out, documented and reported;
- ensuring that the approach to information handling is communicated to all staff and made available to the public;
- ensuring that appropriate training is made available to staff and completed as necessary to support their duties and for NHS organisations;

- liaising with other committees, working groups and programme boards in order to promote and integrate IG standards;
- monitoring information handling activities to ensure compliance with law and guidance; and
- Providing a focal point for the resolution and/or discussion of IG issues.

Patient Safety Team It is the responsibility of the patient safety team to ensure a system is in place which enables the CCG to report incidents in accordance with good Information Governance Principles. It is the responsibility of the patient safety team to lead the NELCCG Incident monthly meetings, ensuring incidents are monitored for themes and trends and action is proportionate and appropriate. It is the responsibility of the Patient Safety Team to liaise with partner agencies, including other CCG's and NHS England, when appropriate. The Patient Safety Team should ensure the Designated Nurse for Safeguarding Children and Adults are aware of any Incidents or SIs where safeguarding concerns are explicitly identified in the notifications, or where:

- a child or adult has died or has suffered harm where abuse or neglect is suspected (including as a result of healthcare provided or omitted)

Safeguarding Team. It is the responsibility of the Designated Nurse for Safeguarding Children and Adults to ensure oversight of safeguarding themes emerging from Incidents and SIs, and where a statutory safeguarding notification or response is required, this is actioned.
The Designated Nurse for Safeguarding will act as the conduit between the Incidents /SI processes/ meetings and statutory/ learning lessons review processes undertaken by the relevant Local Safeguarding Children or Adult Boards (LSCB/SAB).

The Information Governance Steering Group The Information Governance Group is a standing committee accountable to the Quality Group. The group's purpose is to support and embed the broader information governance agenda within the organisation and provide the Governing Body with assurance that effective information governance is in place within the organisation. The group is responsible for the following areas of work:

- Confidentiality and Consent;
- Data Protection;
- Data Quality;
- Information Management;
- Information Disclosure and Sharing;
- Information Security;
- Records Management;
- Registration Authority;
- Access Control;
- Information Governance Incident Reporting; and
- Freedom of Information.

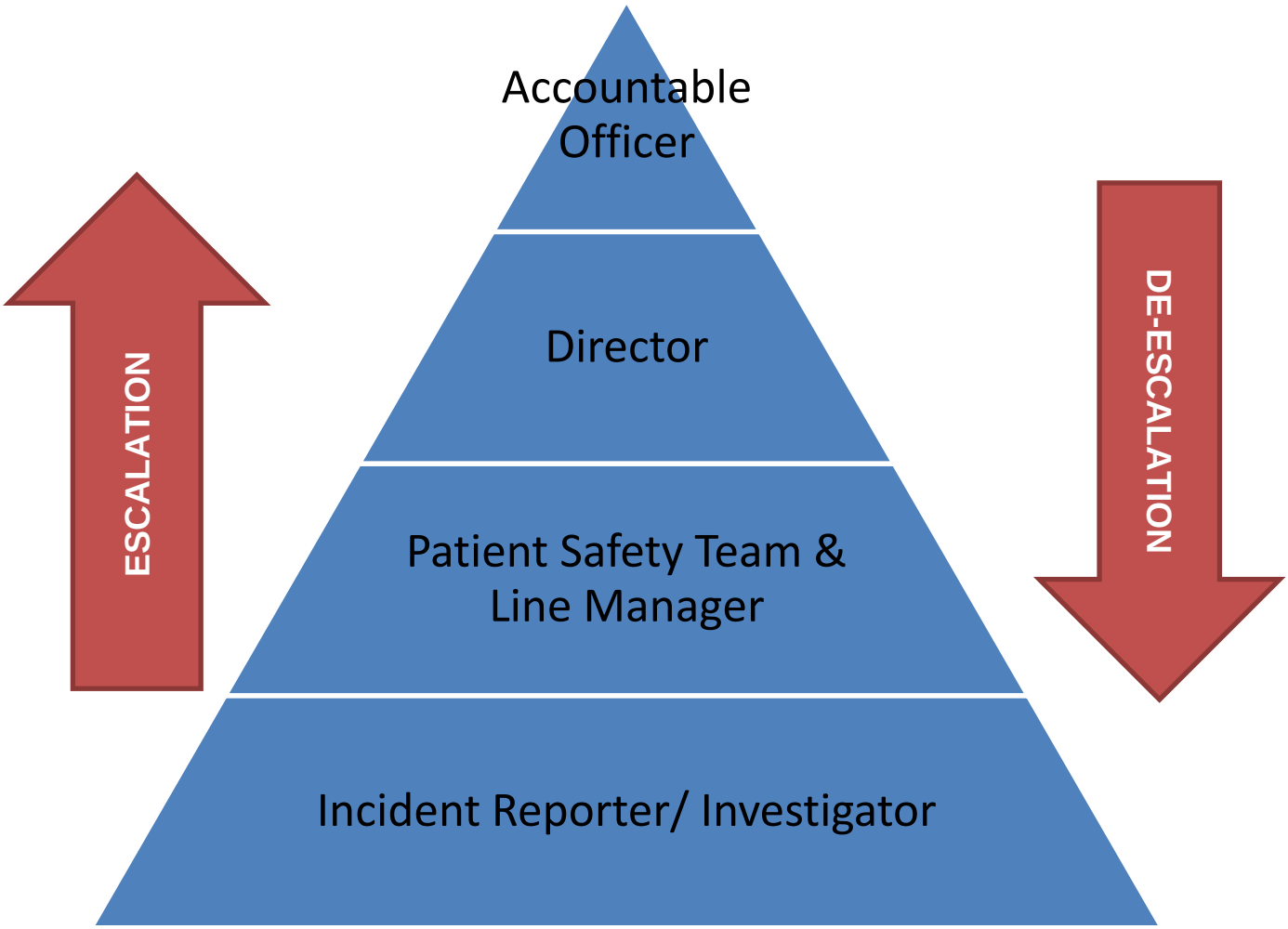
Quality Group The specific role of the Group with regard to this policy is to scrutinise the themes and trends in incident and serious incident reporting and make recommendations for changes in practice as appropriate. The Group is required to

identify any significant exceptions and appraise the Governing Body of related risks and remedial action required.

Governing Body- the Governing Body is responsible for ensuring the CCG has appropriate arrangements in place to exercises its functions effectively, efficiently and economically and in accordance with the CCG's principals of good governance. Is made up of a membership that includes doctors and healthcare professionals, executive members and local authority and lay members. The Governing Body also;

- Leads the setting of vision and strategy
- Approves commissioning plans developed in conjunction with member practices
- Monitors performance against plans
- Provides assurance against strategic risk
- Has a duty to Commission health care services within available resources.

Escalation and de-escalation process for raising and responding to items of concern/identified risk following reporting of an incident



5. **Reporting Incidents**

The electronic incident reporting form, accessed via the Incident Application, should be used by staff conducting business on behalf of the CCG to report incidents to the CCG. It is the responsibility of all staff to report an incident within 48 hours of identification (or 24 hours if the incident is deemed to be serious). The incident form should be used to report the facts of the incident, not opinion, as comprehensively and concisely as possible. The member of staff involved in the incident, or someone who notices it, should complete the form. Any remedial action that is undertaken or planned should be noted on the form. The immediate priority for all staff in the case of an incident is to take steps necessary to secure the safety of the staff member and other people involved. Prompt action must be initiated to prevent a reoccurrence of any incident or to minimise the risk of a near miss or potential incident from materialising into an actual incident. The type of immediate action required varies according to the nature of the occurrence. Action may include;

- Administering first-aid;
- Taking a faulty piece of equipment out of action;
- Closing a workplace until repairs can be effected;
- Changing a working practice to prevent re-occurrence.

Serious incidents must be reported in accordance with the CCG's Serious Incident Policy and Procedure (2017). This includes completing an incident form and reporting to the Patient Safety Team by the fastest means – telephone or email NLCCG.SeriousIncidents@nhs.net

NLCCG commissioned General Practice Providers also have NLCCG Incident Application access enabling General Practice to report and record incidents directly to the CCG.

NLCCG commissioned providers, excluding General Practice, are advised to report incidents which have occurred in another provider to NLCCG.Incidents@nhs.net All incidents reported into this email are administered by the Patient Safety Team and entered into the NLCCG Incident Application.

Levels of investigation
Not all incidents reported to the CCG are investigated. NLCCG Incident Application mandates that the reporter considers whether an investigation is required. If the immediate actions identify the root causes of the incident an investigation is not necessary. The Patient Safety Team review the incidents reported on the application and the decision to investigate. The Patient Safety Team, if required, is able to override the decision to investigate.

The majority of incidents reported to NLCCG which require investigation simple Root Cause Analysis (RCA) is indicated. For all NLCCG assigned incidents the simple RCA form must be completed and returned to NLCCG.Incidents@nhs.net

Assigning an Investigator
For incidents which occur within NLCCG it is the responsibility of the Line Manager to ensure a robust investigation of the incident occurs and findings and action taken is recorded on the simple RCA form.

For incidents which occur outside of NLCCG within a service provider it is the responsibility of the Provider to assign an appropriate Investigator.

6. **Reporting to external agencies**

Estates and Facilities
Incidents concerning NLCCG estates and facilities must be reported to the business manager who will liaise with NHS Property Services.

NHS England
- All Controlled Drug incidents occurring in Primary Care Providers must be reported to NHS England by utilising the Controlled Drugs Incident Reporting Form
- All Immunisation and Vaccinations incidents must be reported to NHS England
- All Primary Care Serious Incidents and Professional performance incidents must be reported too NHS England utilising the Professional Performance Incident Form

Police
All incidents where criminal activity is suspected or proven must be escalated to Line Managers and the duty to inform the police discharged.

Professional Bodies – CQC and Professional Body Membership
If concerns about a professionals practice are identified duty to report to the appropriate professional body should be discharged.

National Reporting and Learning System (NRLS)
The responsibility for reporting to NRLS remains with the Provider and their local policy and procedures.

Information Governance (IG) Incidents and Information Commissioner
All information Governance Incidents assessed as Level 2 must be reported on the IG Toolkit and to the Information Commissioner. It is the responsibility of the Provider in which the incident occurred to assess the level of the incident and take appropriate action in accordance with IG National Procedures. NLCCG IG Incidents please refer to Appendix G.

Medicines and Healthcare Products Regulatory Agency (MHRA)
Any adverse incident involving a medical device or adverse reaction to medications should be reported as soon as possible. Electronic reporting using the online form on the MHRA website (www.mhra.gov.uk) is the preferred method.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR)
The Incident Application replaces the requirement for an Accident Book for the CCG. All Accidents must be reported on the Incident Application. Providers are expected to have in place their own processes for reporting and recording workplace accidents.

All CCG accidents require an assessment to be made by the Line Manager against the RIDDOR requirements. All CCG workplace accidents must have a RIDDOR assessment documented. If the incident meets RIDDOR requirements entering the Serious Incident Process must be considered.

7. Reviewing an investigation Response

All incidents which require investigation are reviewed by the Head of Nursing prior to sharing the response with the reporting agency this is to allow consistency of clinical review the Monitoring & acting on themes and trends prior to sharing the response/learning with the reporting agency.

8. Monitoring and Responding to Themes and Trends

All Incidents reported on the NLCCG Incident APP are monitored at the Incident Group meeting via a monthly report specifically run for trends and themes in each Category raised, these are then aligned with the Head of nursing's intelligence from reviewing provider incident responses and together monitored for themes and trends and acted upon as necessary by the group. A quarterly Incident report is taken to the

Quality Group for Overview, scrutiny and discussion for means and dissemination routes of sharing lessons learnt to the wider CCG and providers as necessary as well as highlighting any exceptions to the Governing body.

9. TRAINING

Line managers must inform new starters as part of their induction, requirements of this policy and how to report incidents using the online incident APP. Staff required to review provider Incident Reports or/and conduct investigations must be trained in Root Cause Analysis.

10. IMPACT ANALYSES

Equality

As a result of preforming the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. (Appendix K)

Bribery Act 2010

The CCG follows good NHS business practice as outlined in the Business Conduct Policy and the Conflicts of Interest Policy and has robust controls in place to prevent fraud, bribery and corruption. Due consideration has been given to the Bribery Act 2010 in the development (or review, as appropriate) of this policy document and no specific risks were identified

11. IMPLEMENTATION

Notification of this Policy and Standard Operating Procedure will be disseminated via the NLCCG Newsletter, a verbal notification at Team Briefing and Line Managers will be asked to brief staff on the implementation of this policy document.

12. MONITORING AND REVIEW

This policy will be reviewed in 3 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this policy.

Compliance with this Policy document will be reviewed through staff feedback, incidents and audit, when appropriate.

13. REFERENCES AND LINKS TO OTHER DOCUMENTS

- NHS England (2015) Serious Incident Framework.
- NLCCG (2017) Incident Policy and Procedure.
- NLCCG () Information Governance Policy

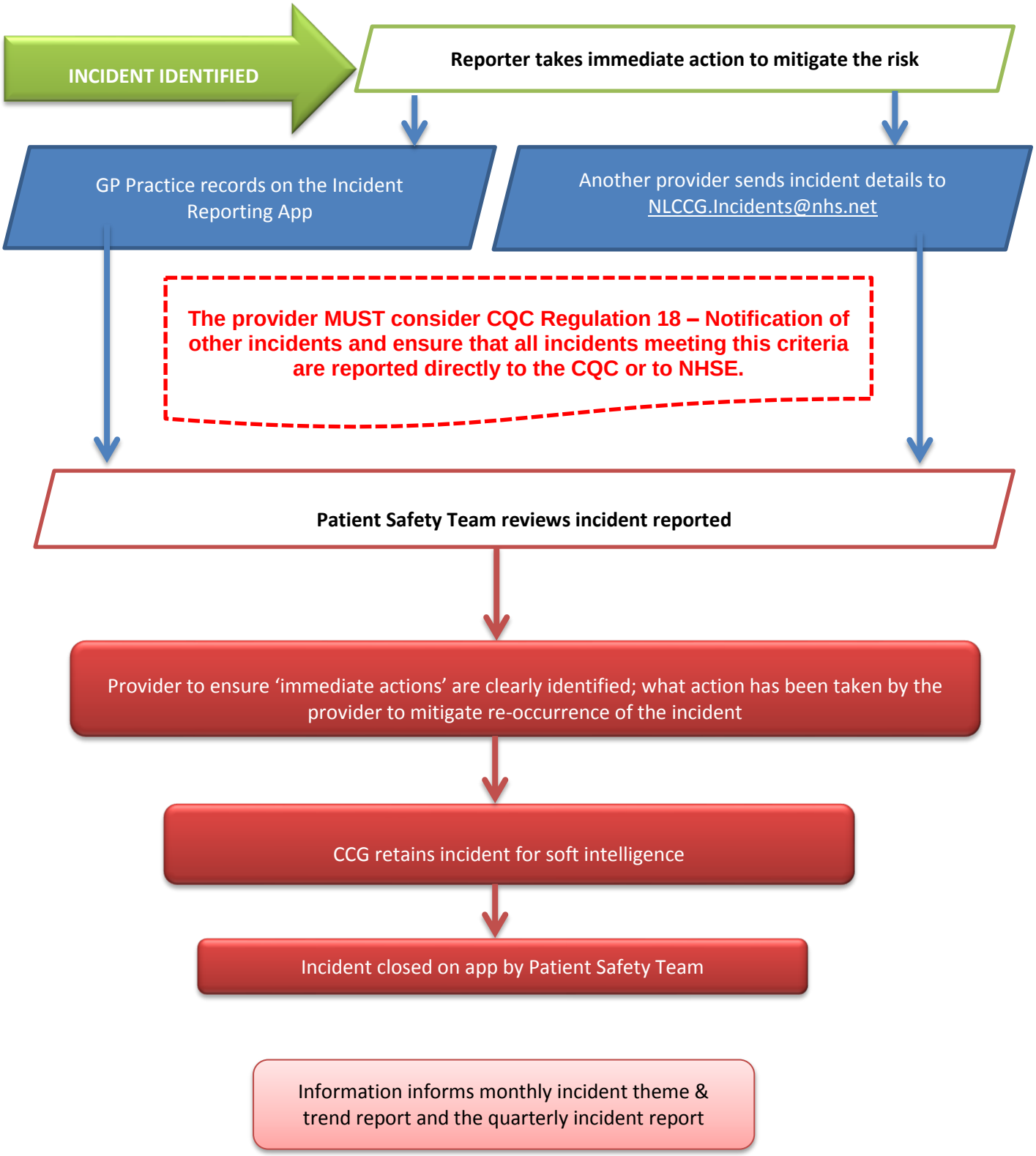
- HSCIC (2015) Checklist Guidance for reporting, managing and investigating information governance and cyber security serious incidents requiring investigation. HSCIC.

14. APPENDICES

Appendix A – Abusive, violent or self-harming behaviour
Appendix B – Access, appointment, admission, transfer or discharge
Clinical Assessment
Consent, confidentiality or communication
Patient Information
Appendix C – Accident that may result in personal injury
Appendix D – Health & Safety (CCG Staff)
Appendix E – Immunisation/Vaccination
Appendix F – Implementation of care/on-going monitoring or review
Appendix G – Information Governance
Appendix H – Medication
Appendix I – Pressure Ulcer
Appendix J – Security
Appendix K – Equality Impact Assessment

Appendix A:
Abusive, violent, self-harming behaviour

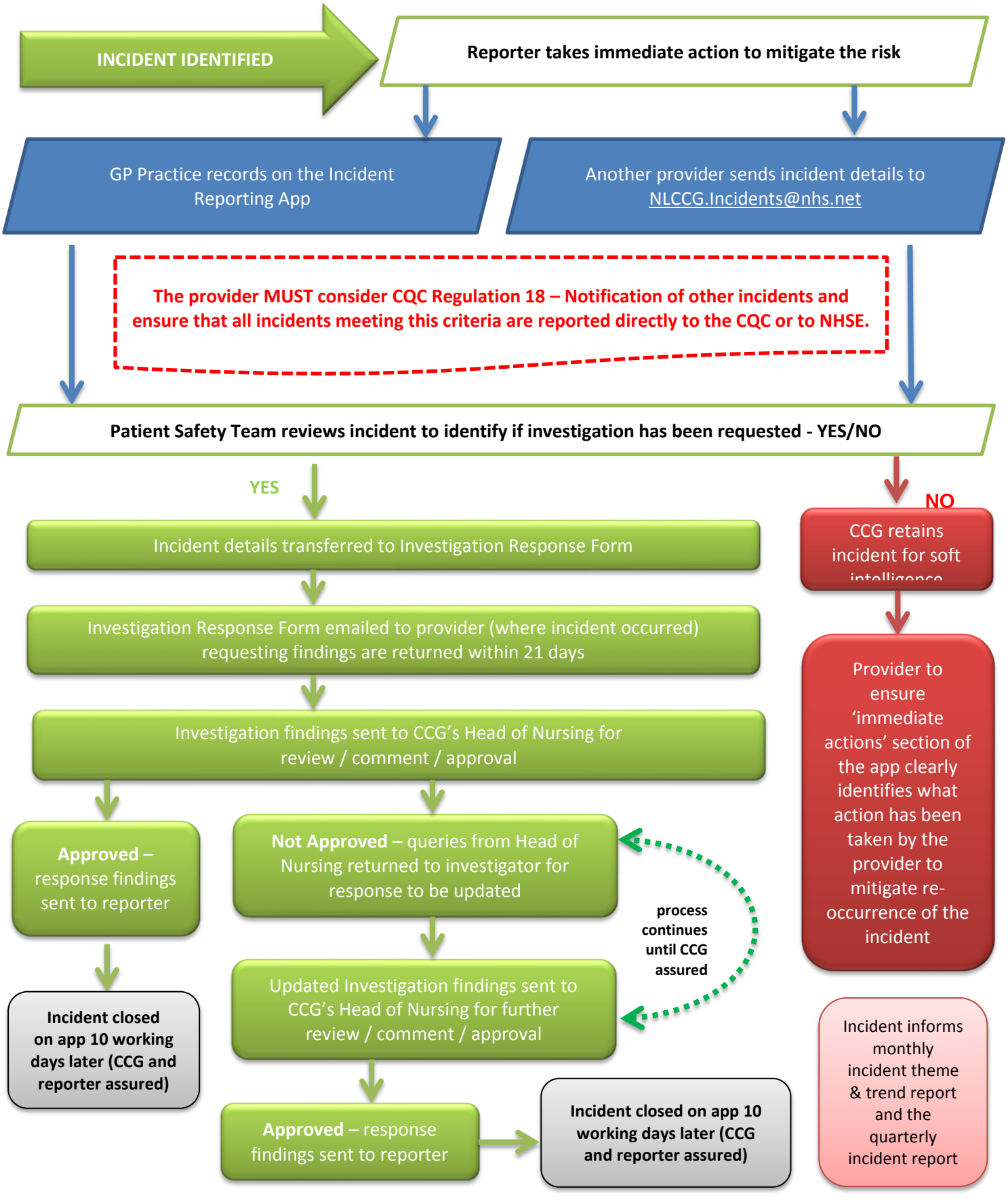
NHS
North Lincolnshire
Clinical Commissioning Group



Appendix B:

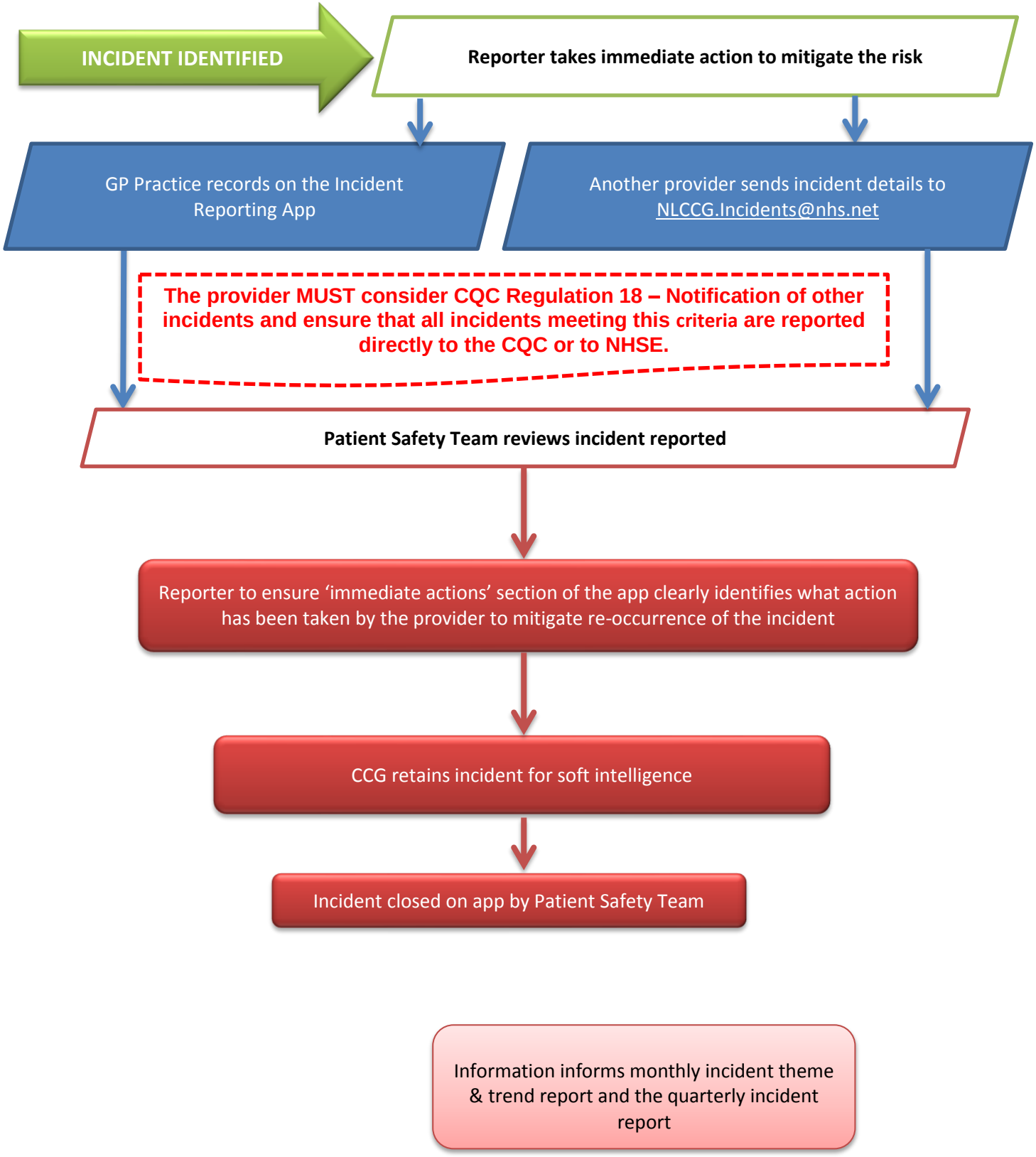
- Access, appointment, admission, transfer, discharge
- Clinical Assessment
- Consent, confidentiality or communication
- Patient Information

NHS
North Lincolnshire
Clinical Commissioning Group



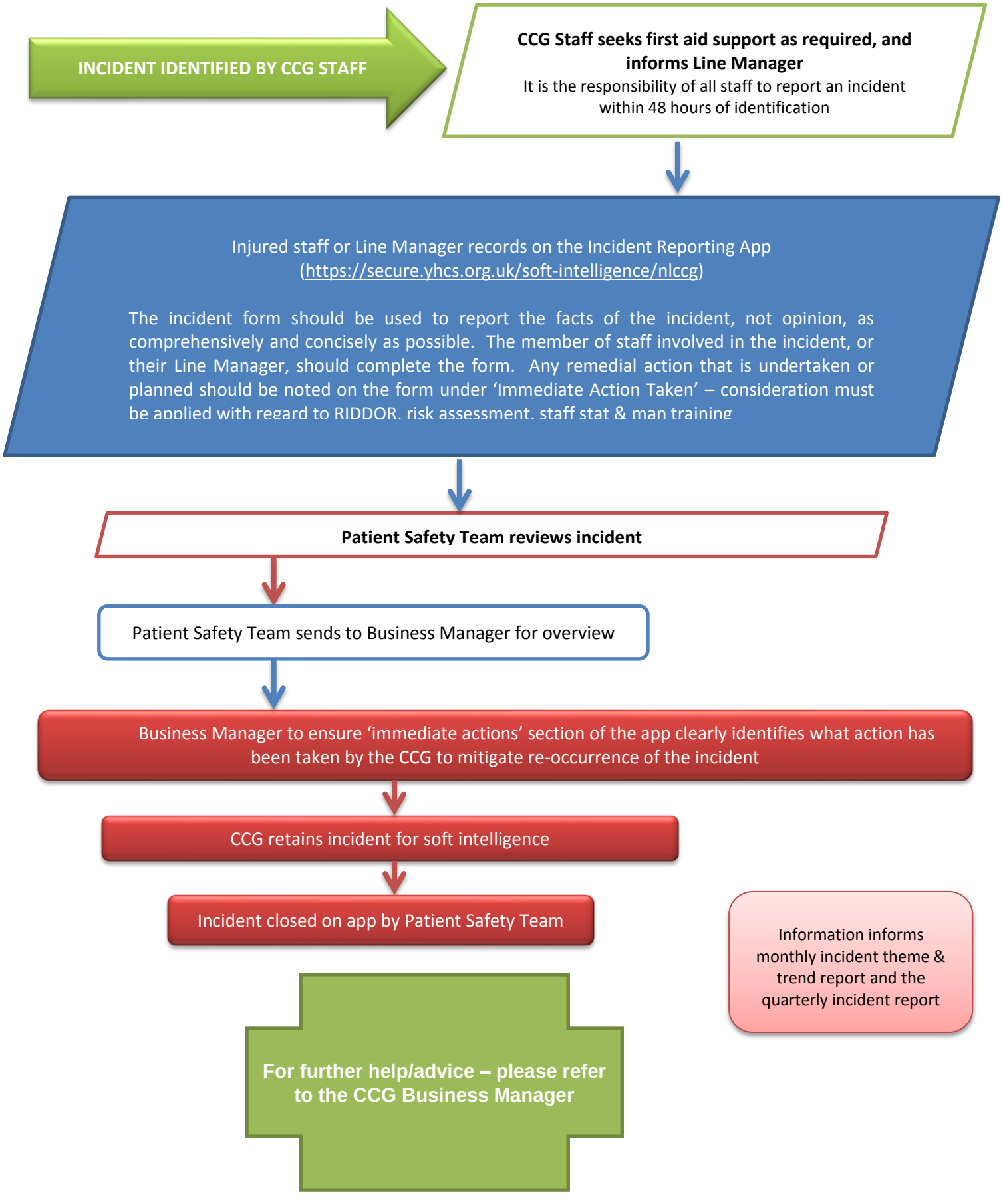
Appendix C:
Accident that may result in personal injury

NHS
North Lincolnshire
Clinical Commissioning Group



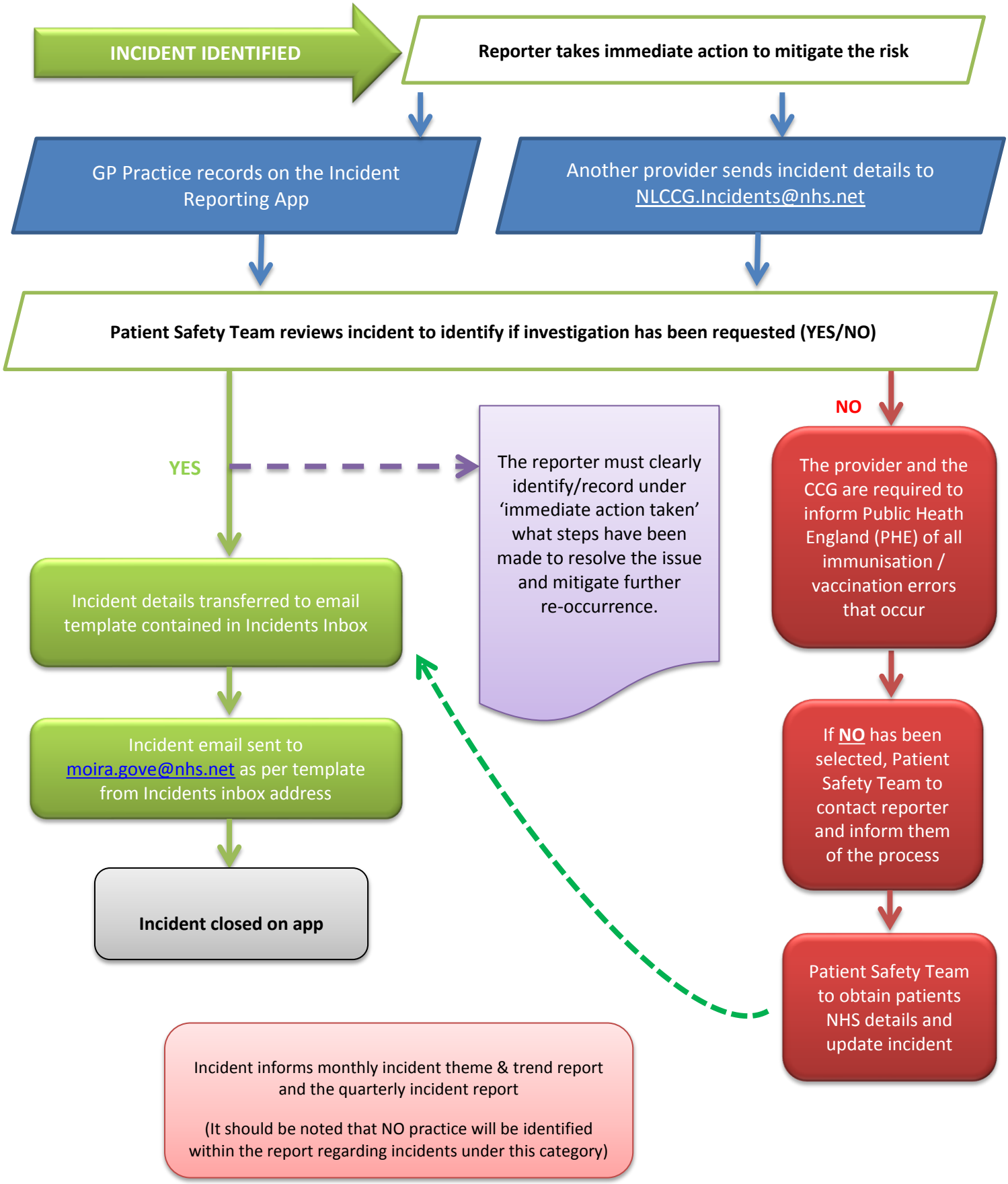
Appendix D:
Health & Safety (CCG Staff only)

NHS
North Lincolnshire
Clinical Commissioning Group



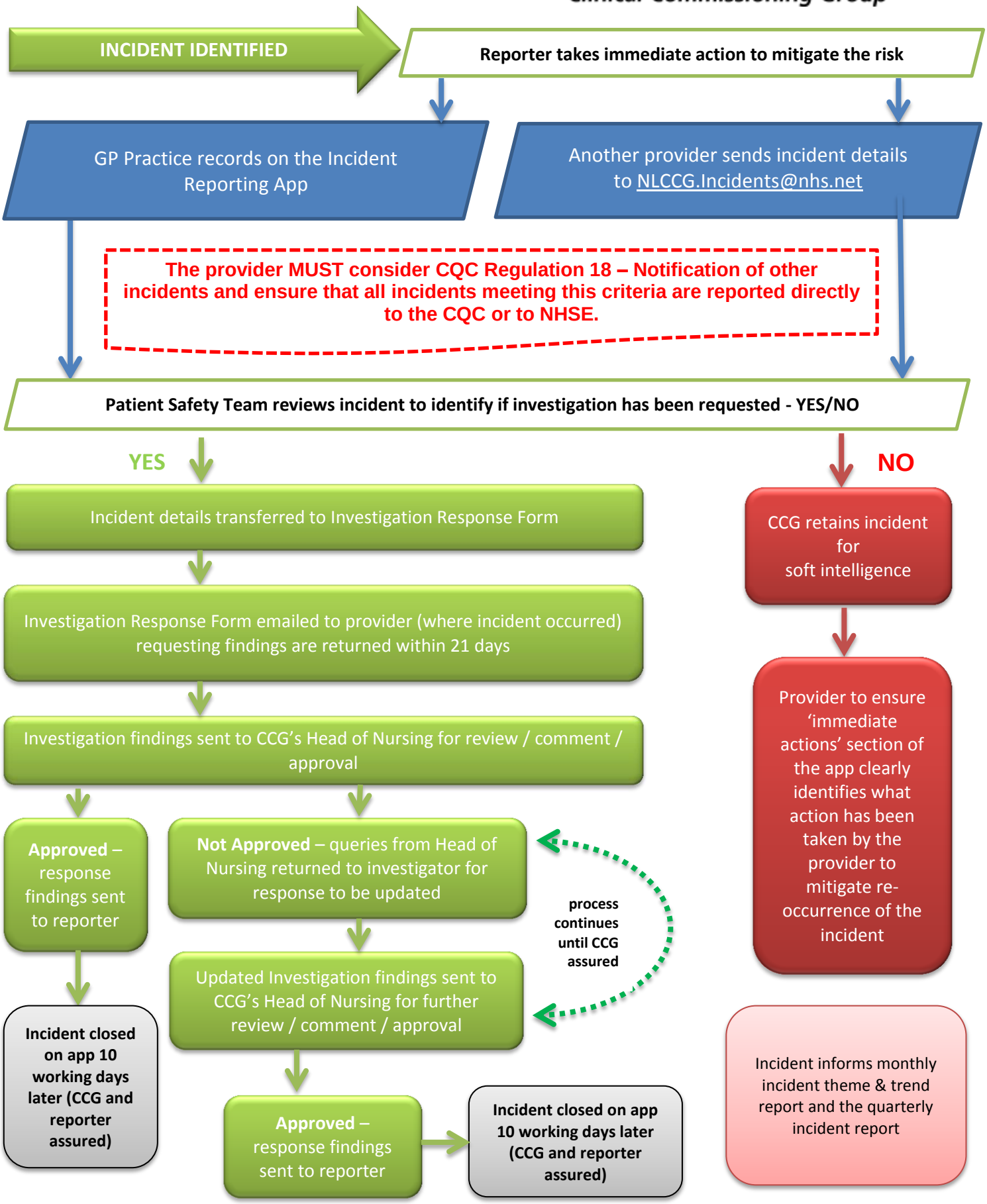
Appendix E:
Immunisation/Vaccination

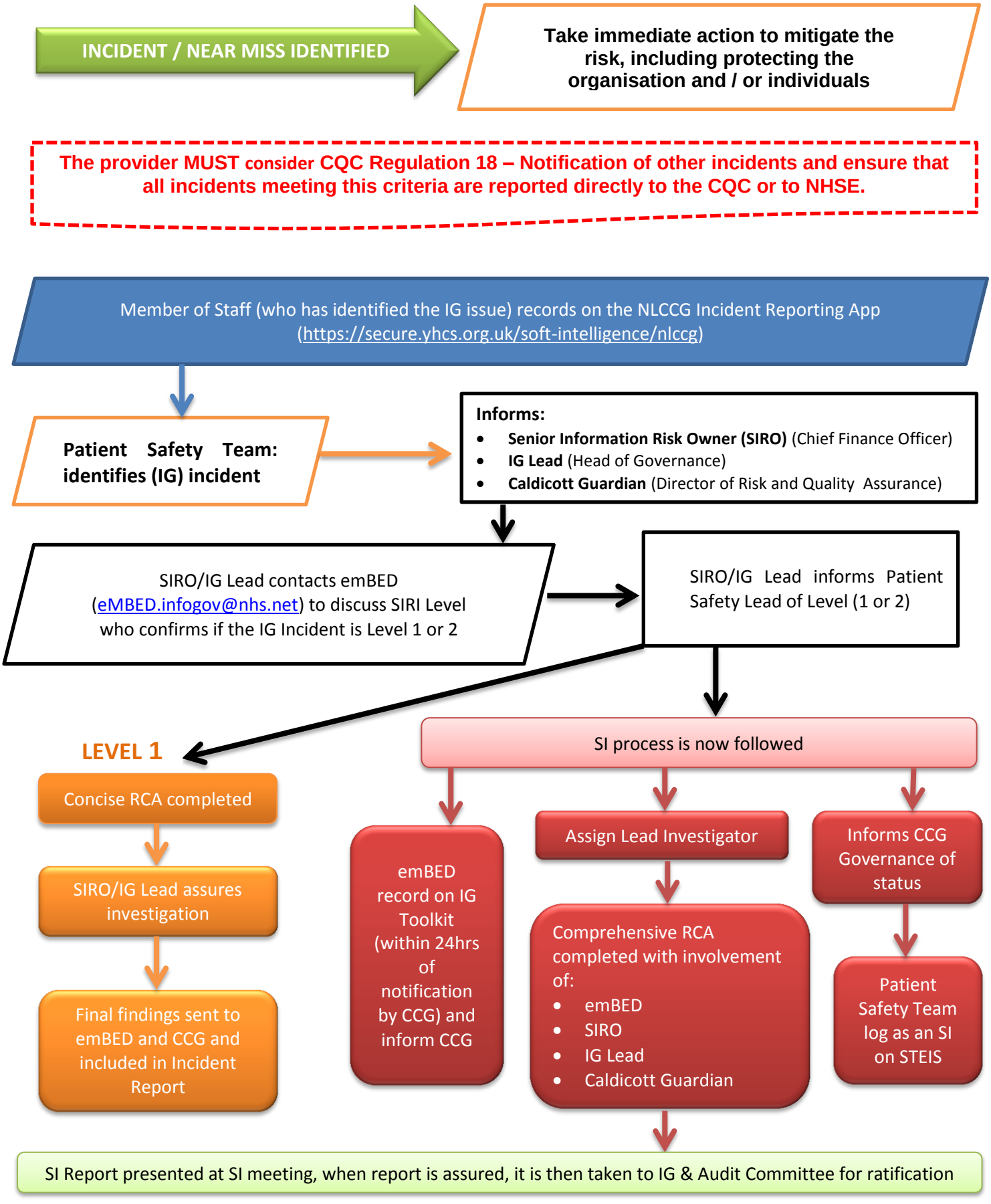
NHS
North Lincolnshire
Clinical Commissioning Group



Appendix F:
Implementation of care or ongoing monitoring/review

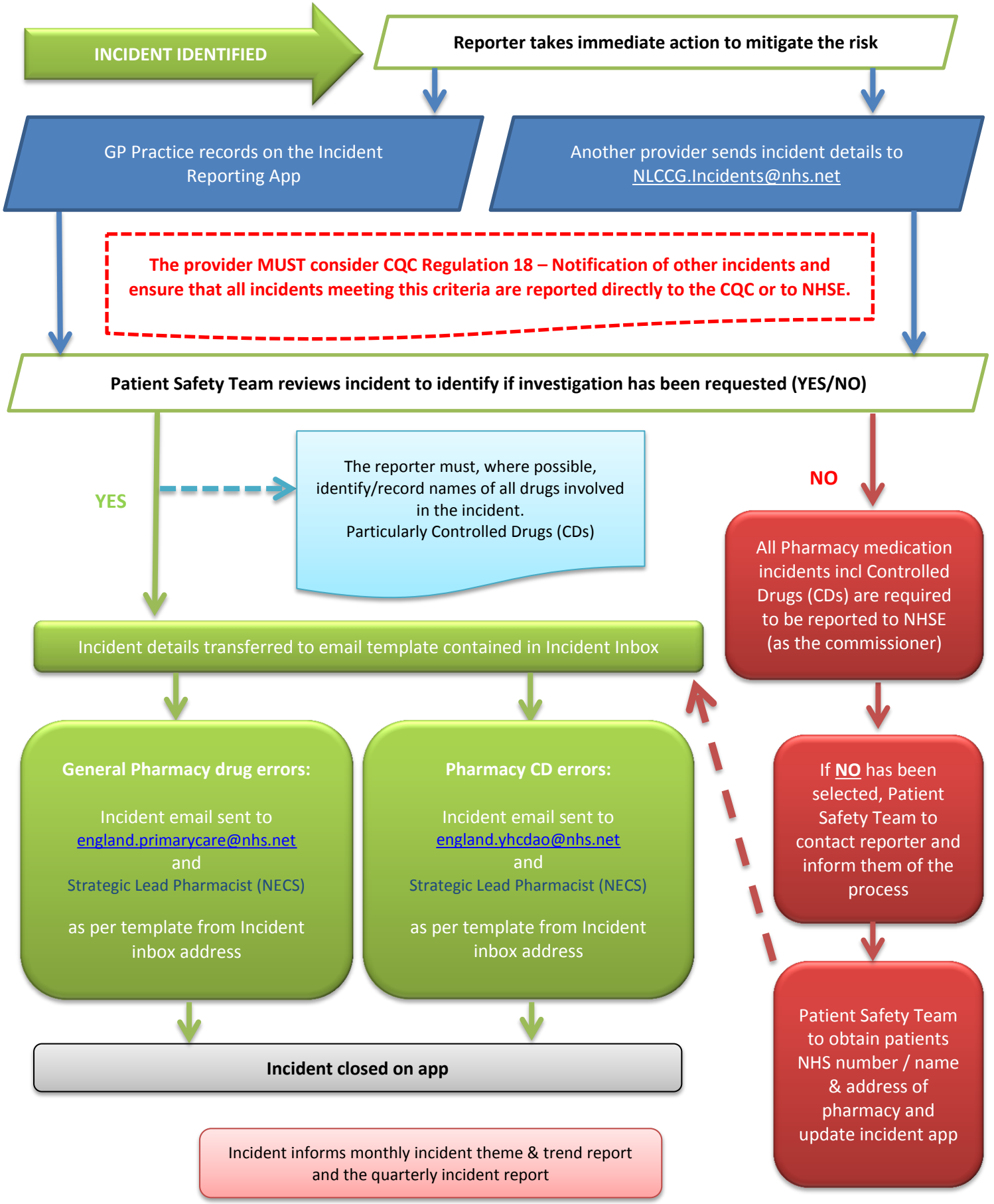
NHS
North Lincolnshire
Clinical Commissioning Group




INCIDENT / NEAR MISS IDENTIFIED
Take immediate action to mitigate the risk, including protecting the organisation and / or individuals
The provider MUST consider CQC Regulation 18 – Notification of other incidents and ensure that all incidents meeting this criteria are reported directly to the CQC or to NHSE.
Member of Staff (who has identified the IG issue) records on the NLCCG Incident Reporting App (https://secure.yhcs.org.uk/soft-intelligence/nlccg)
Patient Safety Team: identifies (IG) incident
Informs:
Senior Information Risk Owner (SIRO) (Chief Finance Officer)
IG Lead (Head of Governance)
Caldicott Guardian (Director of Risk and Quality Assurance)
SIRO/IG Lead contacts emBED (eMBED.infogov@nhs.net) to discuss SIRI Level who confirms if the IG Incident is Level 1 or 2
SIRO/IG Lead informs Patient Safety Lead of Level (1 or 2)
LEVEL 1
SI process is now followed
Concise RCA completed
SIRO/IG Lead assures investigation
Final findings sent to emBED and CCG and included in Incident Report
emBED record on IG Toolkit (within 24hrs of notification by CCG) and inform CCG
Assign Lead Investigator
Comprehensive RCA completed with involvement of:
emBED
SIRO
IG Lead
Caldicott Guardian
Informs CCG Governance of status
Patient Safety Team log as an SI on STEIS
SI Report presented at SI meeting, when report is assured, it is then taken to IG & Audit Committee for ratification

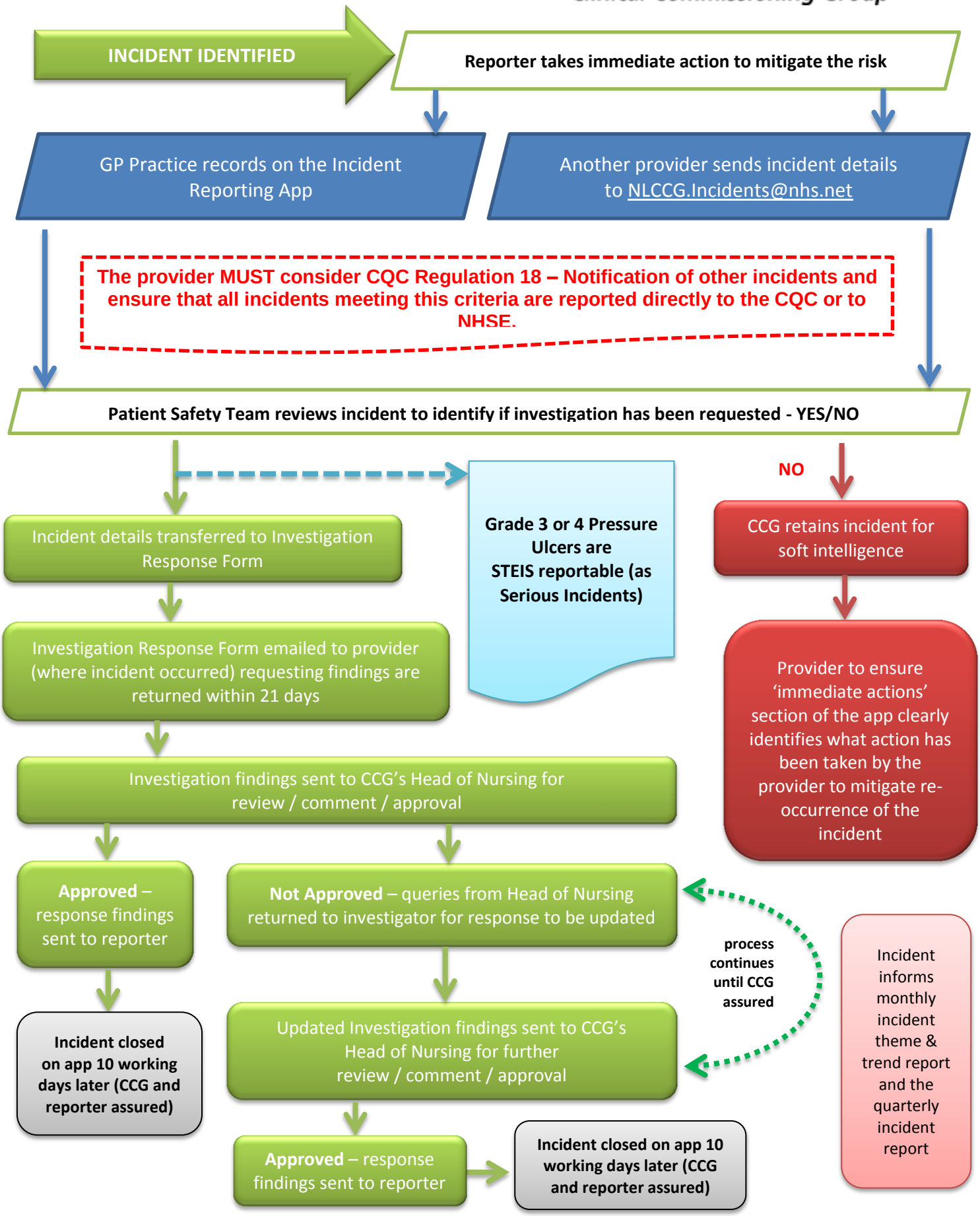
Appendix H:
Medication

NHS
North Lincolnshire
Clinical Commissioning Group



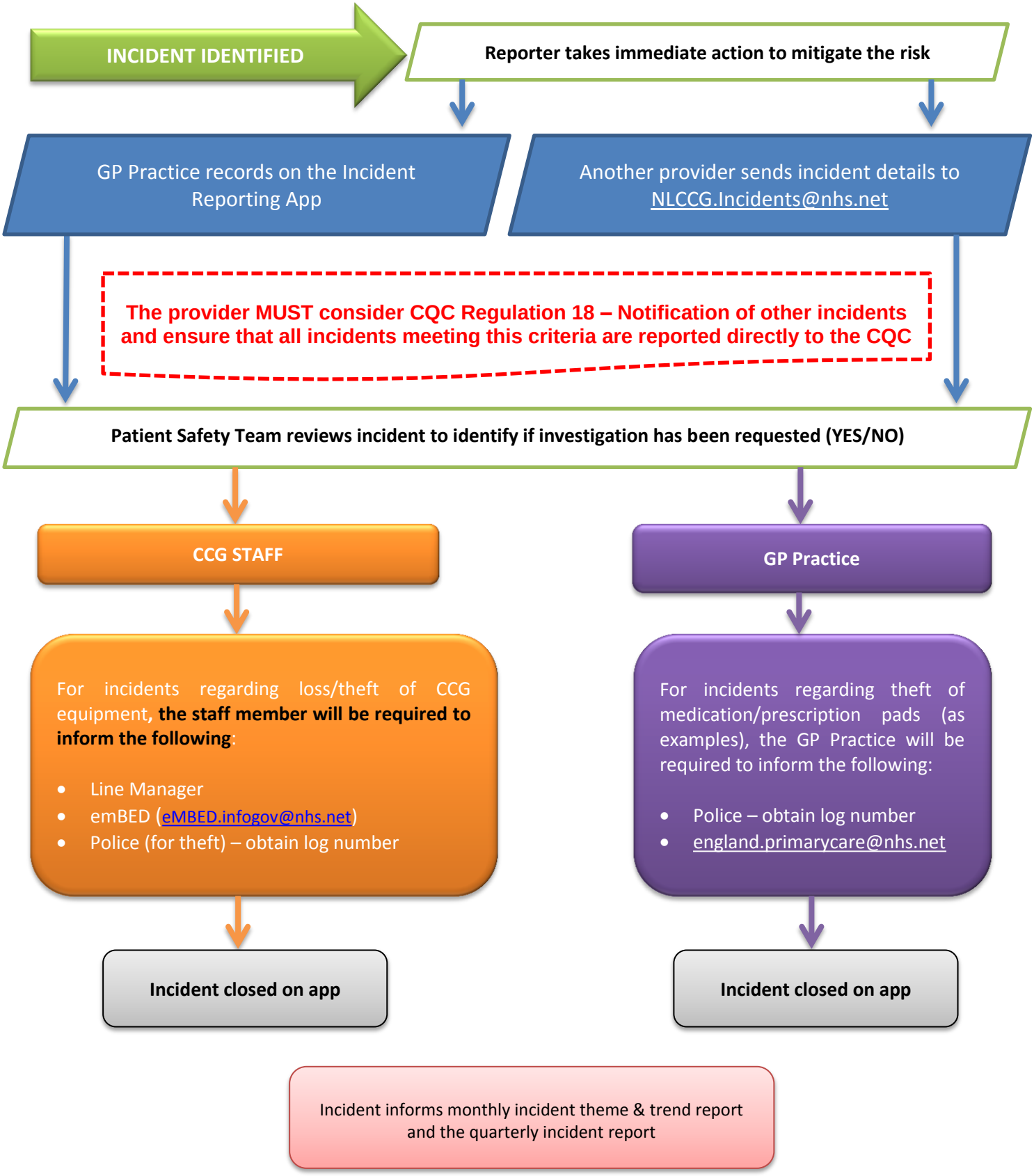
Appendix I:
Pressure Ulcer (Grade 1 and 2 only)

NHS
North Lincolnshire
Clinical Commissioning Group



Appendix J:
Security

NHS
North Lincolnshire
Clinical Commissioning Group



Appendix K:
Impact Equality Assessment

NHS
North Lincolnshire
Clinical Commissioning Group

INTEGRATED IMPACT ASSESSMENT		
Policy/project/function/service	Incident Policy and Standard Operating Procedure	
Date of analysis:	15/03/2017	
Type of analysis completed	Quality	Yes
	Equality	Yes
	Sustainability	Yes
What are the aims and intended effects of this policy/project or function?	To detail responsibilities for the effective management of Incidents in relation to staff and providers responsibilities	
Please list any other policies that are related to or referred to as part of this analysis	Serious Incident Policy and Standard Operating procedure	
Who does the policy, project, function or service affect?	Employees	Yes
	Service users	Yes
	Members of the public	Yes

	Other (please list)	

QUALITY IMPACT							
	Please 'X' ONE for each			**Brief description of potential impact**	**Mitigation strategy and monitoring arrangements**	**Risk 5 x 5 risk matrix)**	
	Chance of Impact on Indicator						
	Positive Impact	**No Impact**	**Negative Impact**			**Likelihood**	**Consequence**
	X	**X**	**X**				
PATIENT SAFTEY							
Patient safety /adverse events	**X**			**Is in line with National guidance**			
Mortality position		**X**					
Infection control MRSA/CDIFF		**X**					
CQC status		**X**					

NHSLA / CNST		**X**					
Mandatory/statutory training	**X**			**Identifies need for Line Managers to highlight and train staff groups on induction**			
Workforce (vacancy turnover absence)		**X**					
Safe environment	**X**			**Identified steps to be taken to promote a safe environment.**			
Standard & suitability of equipment		**X**					
CLINICAL EFFECTIVENESS							
NICE Guidance and National Quality Standards, eg VTE, Stroke, Dementia		**X**					
Patient related outcome measures		**X**					
External accreditation e.g. professional bodies ie RCN		**X**					

CQUIN achievment		**X**					
PATIENT EXPERIENCE							
Will there be an impact on patient experience if so how		**X**					
Will it impact on carers if so how		**X**					
INEQUALITIES OF CARE							
Will it create / reduce variation in care provision?		**X**					
STAFF EXPERIENCE							
What is the impact on workforce capability care and skills?		**X**					
Will there be a change in working practice, if so, how?		**X**					
Will there be an impact on training	**X**			**Identifies need for Line Managers to training staff groups on induction package.**			
TARGETS / PERFORMANCE							

Will it have an impact on performance, if so, how?	**X**			**Provides guidance on best practice.**			
Could it impact on the achievment of local, regional, national targets, if so, how?		**X**					

EQUALITY IMPACT							
Analysis Rating (see completion notes)	Red		Red/Amber		Amber	Green	X
Approved by:	Commissioner Lead:			GP lead for E&D:			
	Date			Date			

Local Profile Data	
General	N/A
Gender (Men and Women)	
Race (All Racial Groups)	

Disability (Mental and Physical, Sensory Impairment, Autism, Mental Health Issues)	
Religion or Belief	
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	
Pregnancy and Maternity	
Transgender	
Marital Status	
Age	
Equality Data	
Is any equality data available relating to the use or implementation of this policy, project or function?	No Impact

List any consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function.	Policy developed by Patient Safety Lead and shared with Quality team colleagues for consultation and Lay members at the Quality Group.
Promoting inclusivity; How does the project, service or function contribute to our aims of eliminating discrimination and promoting equality and diversity?	No specific impact

Equality Impact Risk Assessment test

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010*?

Protected Characteristic:	No Impact	Positive Impact	Negative Impact	Evidence of impact and if applicable justification where a *Genuine Determining Reason* exists
Gender (Men and Women)	X			
Race (All Racial Groups)	X			
Disability (Mental and Physical, Sensory Impairment, Autism, Mental Health Issues)	X			

Religion or Belief	X			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	X			
Pregnancy and Maternity	X			
Transgender	X			
Marital Status	X			
Age	X			

Action Planning

As a result of performing this Equality Impact Analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by The Equality Act 2010?

Identified Risk:	Recommended Action:	Responsible Lead	Completion Date	Review Date
Nil				

SUSTAINABILITY IMPACT				
Staff preparing a Policy / Board Report / Committee Report / Service Plan / Project are required to complete a Sustainability Impact Assessment. Sustainability is one of the Trust's key Strategies and the Trust has made a corporate commitment to address the environmental effects of activities across Trust services. The purpose of this Sustainability Impact Assessment is to record any positive or negative impacts that this activity is likely to have on each of the Trust's Sustainability Themes.				
	Positive Impact	**Negative Impact**	**No Specific Impact**	**What will the impact be? If the impact is negative, how can it be mitigated? (action)**
Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020			X	
New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.			X	
Reduce the risk of pollution and avoid any breaches in legislation.			X	
Goods and services are procured more sustainability.			X	
Reduce carbon emissions from road vehicles.			X	
Reduce water consumption by 25% by 2020.			X	

Ensure legal compliance with waste legislation.			X	
Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020			X	
Increase the amount of waste being recycled to 40%.			X	
Sustainability training and communications for employees.			X	
Partnership working with local groups and organisations to support sustainable development.			X	
Financial aspects of sustainable development are considered in line with policy requirements and commitments.			X	