

Health Services Safety Investigations Body

## **Equality Impact Assessment**

# Equality Impact Assessment: HSSIB Strategy and Investigation Criteria

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## Background

HSSIB is committed to ensuring that its work does not negatively impact on anyone, particularly individuals or groups who are disadvantaged or who have a Protected Characteristic as defined by the Equality Act 2010.

The Equality Impact Assessment (EIA) process is an approach designed to improve equality analysis, practice, and outcomes. Whilst it is a key part of the evidence that is needed to demonstrate compliance with the Equality Act's Public Sector Equality Duty, the most important outcome of this process is showing how HSSIB's work can make a real difference to the lives of people from all communities.

During the development of the strategy and criteria, HSSIB has engaged with a wide variety of stakeholders. A core consideration in development of the strategy and criteria was to ensure a wide engagement process, ensuring that a diverse range of opinions and insights were captured.

New evidence and data are continually being captured, and so this EIA has been developed based on available evidence and data at this time.

## Key findings: investigation criteria

### Age

#### **Positive impact**

HSSIB investigations can consider elements of healthcare that may be more relevant to improving safety in different age groups, from neonatal care through to the care of older adults. Deeper insight into how care is delivered in the context of age can help to improve safety in these populations. Previous investigation work has aimed to improve safety in these groups and future investigation work may be able to provide further improvements via our investigation criteria. Examples of positive impacts from these population groups from previous HSIB and HSSIB work include:

HSIB. (2018). Transition from child and adolescent mental health services to adult mental health services [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/</u>

HSIB. (2019). Undetected button/coin cell battery ingestion in children [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/undetected-button-coin-cell-battery-ingestion-in-children/</u>

HSIB. (2020). Neonatal collapse alongside skin-to-skin contact [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/neonatal-collapse-alongsideskin-to-skin-contact/

HSIB. (2020). The role of clinical pharmacy services in helping to identify and reduce high-risk prescribing errors in hospital [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/the-role-of-clinical-pharmacy-services-in-helping-to-identify-and-reduce-high-risk-prescribing-errors-in-hospital/">https://www.hssib.org.uk/patient-safety-investigations/the-role-of-clinical-pharmacy-services-in-helping-to-identify-and-reduce-high-risk-prescribing-errors-in-hospital/</a>

HSIB. (2021). Management of chronic asthma in children aged 16 years and under [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/</u> management-of-chronic-asthma-in-children-aged-16-years-and-under/

HSIB. (2021). Recognition of the acutely ill infant [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/recognition-of-acutely-ill-infant/">https://www.hssib.org.uk/patient-safety-investigations/recognition-of-acutely-ill-infant/</a>

HSIB. (2022). Weight-based medication errors in children [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/weight-based-medicationerrors-in-children/

HSIB. (2022). Unintentional overdose of paracetamol in adults with low bodyweight [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/</u> unintentional-overdose-of-paracetamol-in-adults-with-low-bodyweight/

## Disability

**Positive impact** 

HSSIB investigations can consider elements of healthcare that may be more relevant to improving safety in people with differing healthcare needs and disabilities. Deeper insight into how care is delivered in the context of different disabilities and healthcare needs can help to improve safety in these populations. Previous investigation work has aimed to improve safety in these groups and future investigation work may be able to provide further improvements via our investigation criteria.

Examples of positive impacts for these population groups from previous HSIB and HSSIB work include:

HSIB. (2018). Provision of mental health care to patients presenting at the emergency department [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/provision-mental-health-care-patients-presenting-emergency-department/</u>

HSIB. (2019). Lack of timely monitoring of patients with glaucoma [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/lack-of-timely-monitoring-of-patients-with-glaucoma/</u>

HSIB. (2020). Undiagnosed cardiomyopathy in a young person with autism [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/undiagnosed-</u> <u>cardiomyopathy-in-a-young-person-with-autism/</u>

HSIB. (2022). Medicine omissions in learning disability secure units [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/medicine-omissions-in-learning-disability-secure-units/</u>

HSIB. (2023). Care delivery within community mental health teams [online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/care-delivery-</u> within-community-mental-health-teams/

HSIB. (2023). Safety risk of air embolus associated with central venous catheters used for haemodialysis treatment [Online]. Available at: <u>https://www.hssib.org.uk/</u>patient-safety-investigations/safety-risks-associated-with-central-venous-cathetersused-for-haemodialysis-treatment/

HSIB. (2023). The selection and insertion of vascular grafts in haemodialysis patients [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/the-selection-and-insertion-of-vascular-grafts-in-haemodialysis-patients/">https://www.hssib.org.uk/patient-safety-investigations/the-selection-and-insertion-of-vascular-grafts-in-haemodialysis-patients/</a>

HSIB. (2023). Caring for adults with a learning disability in acute hospitals [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/caring-for-adults-with-learning-disabilities-in-acute-hospitals/</u>

HSIB. (2024). Advanced airway management in patients with a known complex disease [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-</u> investigations/advanced-airway-management-in-patients-with-a-known-complexdisease/

HSSIB. (2024). Mental health inpatient settings – Ongoing [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatientsettings/

HSSIB. (2024). The clinical observation of patients detained under the Mental Health Act at risk of self-harm in acute hospitals – Ongoing [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/the-clinical-observation-ofpatients-detained-under-the-mental-health-act-at-risk-of-self-harm-in-acutehospitals/

## **Gender reassignment**

#### **Positive impact**

Previous investigation work has aimed to improve safety in this group and future investigation work may be able to provide further improvements via our investigation criteria.

An example of a positive impact for this group from HSIB work is:

HSIB. (2022). Provision of care for children and young people when accessing specialist gender dysphoria services [Online]. Available at: <u>https://www.hssib.org.uk/</u>patient-safety-investigations/provision-of-care-for-children-and-young-people-when-accessing-specialist-gender-dysphoria-services/

### Marriage and civil partnership

Impact not known

It is not anticipated that any investigation work would provide a specific focus, or positive or negative impact, on this group. However, the investigation criteria would allow for specific consideration of this group in investigation selection processes.

### Pregnancy

#### **Positive impact**

HSSIB investigations can consider elements of healthcare that may be more relevant to improving maternity safety. The Maternity and Newborn Safety Investigations (MNSI) programme continues to investigate specific harm, in line with its criteria, in individual incidents. However, the proposed HSSIB criteria allow for additional safety risks to be considered across the maternity care pathway from a national perspective. Previous investigation work has aimed to improve safety in this group and future investigation work may be able to provide further improvements via our investigation criteria.

Examples of positive impacts for this population group from previous HSIB and HSSIB work include:

HSIB. (2020). Delays to intrapartum intervention once fetal compromise is suspected [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/delays-to-intrapartum-intervention-once-fetal-compromise-is-suspected/</u>

HSIB. (2021). Learning from maternal death investigations during the first wave of the COVID-19 pandemic [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/learning-from-maternal-death-investigations-during-the-first-wave-of-the-covid-19-pandemic/">https://www.hssib.org.uk/patient-safety-investigations/learning-from-maternal-death-investigations-during-the-first-wave-of-the-covid-19-pandemic/</a>

HSIB. (2021). Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/severe-brain-injury-early-neonatal-death-and-intrapartum-stillbirth-associated-with-larger-babies-and-shoulder-dystocia/">https://www.hssib.org.uk/patient-safety-investigations/severe-brain-injury-early-neonatal-death-and-intrapartum-stillbirth-associated-with-larger-babies-and-shoulder-dystocia/</a>

HSIB. (2021). Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic 1 April to 30 June 2020 [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/intrapartum-stillbirth-during-covid-19/

HSIB. (2022). Maternity pre-arrival instructions by 999 call handlers [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/maternity-pre-arrival-instructions-by-999-call-handlers/</u>

HSIB. (2022). Emergency neonatal blood transfusion at birth following acute blood loss during labour and/or delivery [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/emergency-neonatal-blood-transfusion-at-birth/">https://www.hssib.org.uk/</a> patient-safety-investigations/emergency-neonatal-blood-transfusion-at-birth/

HSIB. (2022). Management of preterm labour and birth of twins [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/management-of-preterm-labour-and-birth/

HSIB. (2022). The assessment of venous thromboembolism risks associated with pregnancy and the postnatal period [Online]. Available at: <u>https://www.hssib.org.uk/</u>patient-safety-investigations/the-assessment-of-venous-thromboembolism-risksassociated-with-pregnancy-and-postnatal/

HSIB. (2023). Assessment of risk during the maternity pathway [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/assessment-of-risk-during-the-maternity-pathway/

#### Race

#### **Positive impact**

HSSIB investigations can consider elements of healthcare that may be more relevant to improving safety in people of different races. Deeper insight into how care is delivered in this context can help to improve safety in these populations. Previous investigation work has aimed to improve safety in these groups and future investigation work may be able to provide further improvements via our investigation criteria.

Examples of positive impacts for these population groups from previous HSIB and HSSIB work include:

HSIB. (2023). Clinical investigation booking systems failures: written communications in community languages [Online]. Available at: <a href="https://www.hssib.org.uk/patient-safety-investigations/clinical-investigation-booking-systems-failures-written-communications-in-community-languages/">https://www.hssib.org.uk/patient-safety-investigations/clinical-investigation-booking-systems-failures-written-communications-in-community-languages/</a>

HSIB. (2023). Invasive procedures in patients with sickle cell disease [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/invasive-procedures-in-patients-with-sickle-cell-disease/</u>

HSIB. (2023). Management of sickle cell crisis [Online]. Available at: <u>https://</u> www.hssib.org.uk/patient-safety-investigations/management-of-sickle-cell-crisis/

## **Religion or belief**

#### **Positive impact**

It may be unlikely that investigation work would provide a specific focus, or positive or negative impact, based on religion or belief alone. However, considerations about religion or belief will be relevant to multiple HSSIB investigations when considering the religious and cultural context of people and how this may impact on how they receive or deliver healthcare. The proposed criteria would allow for specific consideration of this group in investigation selection processes.

#### Sex

#### **Positive impact**

HSSIB investigations can consider elements of healthcare that may be more relevant to improving safety in people of different sexes. Deeper insight into how care is delivered in this context can help to improve safety in these groups. Previous investigation work has aimed to improve safety in these groups and future investigation work may be able to provide further improvements via our investigation criteria.

Examples of positive impacts for these population groups from previous HSIB and HSSIB work include:

HSIB. (2019). Management of acute onset testicular pain [Online]. Available at: https://www.hssib.org.uk/patient-safety-investigations/management-of-acute-onsettesticular-pain/ HSIB. (2019). Detection of retained vaginal swabs and tampons following childbirth [Online]. Available at: <u>https://www.hssib.org.uk/patient-safety-investigations/</u> <u>detection-of-retained-vaginal-swabs-and-tampons-following-childbirth/</u>

HSIB. (2020). The diagnosis of ectopic pregnancy [Online]. Available at: <u>https://</u> www.hssib.org.uk/patient-safety-investigations/the-diagnosis-of-ectopic-pregnancy/

### **Sexual orientation**

#### **Positive impact**

It may be unlikely that investigation work would provide a specific focus, or positive or negative impact, based on sexual orientation alone. However, considerations relevant to sexual orientation may be relevant to multiple HSSIB investigations when considering the context of people's sexual orientation and how this may impact on how they receive or deliver healthcare. The investigation criteria would allow for specific consideration of this group in investigation selection processes.

## Key findings: HSSIB Strategy

Strategic theme five of the HSSIB Strategy focuses on our own employees namely to - Embed a compassionate, inclusive culture across our organisation.

As part of the equality impact assessment, we have considered whether there is any potential adverse impact of this theme on individuals or groups of employees with specific protected characteristics under the Equality Act 2010. We do not believe there will be any adverse impact and our intention is, by working towards an inclusive and compassionate culture for all employees, our strategy will increase opportunities for everyone to thrive, regardless of their individual characteristics, feeling they belong, are included, valued, respected and are treated with dignity.

As we devise our own HR policies and procedures, we will seek opportunities to build a compassionate and inclusive culture through policy statements, procedures, and the way we operate at HSSIB. Our commitment towards improving the culture is demonstrated in initial actions including appointing an EDI representative on the Board (NED), and an Executive lead with responsibility for Equality, Diversity and Inclusion which will involve demonstrating a commitment to tackling discrimination of any kind within HSSIB and promoting equality in the workplace. All employees at HSSIB are mandated to complete the equality and diversity elearning module every year, to raise awareness and prevent discrimination in the workplace. All employees are required to set a minimum of one annual performance objective which focuses on EDI, as part of their annual appraisal. HSSIB operates fair and inclusive recruitment and selection processes which are based on objective selection criteria and a diverse panel, wherever possible. HSSIB promotes equal opportunities for all employees, ensuring that everyone has the same chance to succeed and progress.

Progress towards achieving all five themes of our Strategy will be monitored regularly. Should evidence from these reviews suggest that there has been an adverse impact on groups of employees with protected characteristics or that employees feel progress towards a more inclusive and compassionate culture is not being made, action will be taken to address any adverse impact.

HSSIB ensures that its communications and engagement processes consider the accessibility needs of its audience. Providing reports in alternative formats such as braille, easy read, audio and translated versions, wherever required and ensuring all venues are DDA complaint.

## Conclusion

The findings of this EIA will be used in wider decisions to tackle and address inequalities and socio-economic issues within our investigation work.

This EIA did not identify any negative impacts on people with protected characteristics from implementation of the criteria and strategy, and there are numerous areas within the criteria and strategy that will have a positive impact on people with protected characteristics or groups.

This EIA will be kept under regular review, HSSIB will seek to incorporate additional data on equalities, diversity and inclusion as data becomes available.