NHS
Tees Valley
Clinical Commissioning Group

Corporate	CCG CO12 Risk Management Policy

Version Number	Date Issued	Review Date
V2	July 2021	July 2023

Prepared By:	Commissioning Support Unit Senior Governance Officer Head of Governance
Consultation Process:	Collaborative Working Group Combined Management Group
Formally Approved:	11 May 2021
Approved By:	Executive Committee
Policy Adopted From:	CO12 TV Risk Management Policy (v1.1) CO14 HAST Risk Management Policy (3.2) CO14 Darlington Risk Management Policy (5) CO14 South Tees Risk Management Policy (4) CO13 DDES Risk Management Policy (4) CO13 North Durham Risk Management Policy (4)

Equality Impact Assessment

Date	Issues
October 2019	Appendix C

POLICY VALIDITY STATEMENT
Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 2 year period.

Version Control

Version	Release Date	Author	Update comments
V1	April 2020	Senior Governance Officer Commissioning Support Unit CCG Head of Corporate Services CCG Finance and Performance Manager	New policy template
V1.1	October 2020	Head of Governance	Amendments to reflect Governing Body reporting requirements and cosmetic wording changes.
V2	May 2021	Senior Governance Officer Commissioning Support Unit	Amendments to reflect change of risk assessment matrix.

Approval

Role	Name	Date
Approval	Combined Management Group	10 March 2020
Approval	Executive Committee	20 October 2020
Approval	Executive Committee	11 May 2021

Contents

1. Introduction

For the purposes of this policy, NHS Tees Valley Clinical Commissioning Group will be referred to as "the CCG".

The Policy sets out the CCG approach to risk and the management of risk in fulfilment of its overall objectives. The principles are consistent with good practice. The adoption and embedding within the organisation of an effective risk management framework and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to ensure business success, continuing financial strength and continuous quality improvement in its operating model.

As part of this Policy it is also acknowledged that not all risks can be eliminated. Ultimately it is for the organisation to decide which risks it is prepared to accept based on the knowledge that an effective risk assessment has been carried out and the risk has been reduced to an acceptable level as a consequence of effective controls.

At its simplest, risk management is good management practice and risk assessment provides an effective management technique for managing the organisation (through the identification of risks and the development of mitigating action). Through this Policy the CCG is keen to ensure that risk management is not seen as an end in itself, but rather a part of an overall management approach that supports the organisation in developing achievable management action.

1.1 Status

This policy is a corporate policy.

1.2. Purpose and scope

1.2.1 The purpose of this policy is to provide an overarching support document to enable staff to understand the need to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the CCG's normal business. It is supported by a detailed Standard Operating Procedure, which guides staff through the process of risk identification and assessment.

The Policy sets out an organisation wide approach to managing risk, in a proportionate, straightforward and clear manner for timely, efficient and cost-effective management of risk at all levels within the organisation.

The Policy aims to:

- ensure that risks to the achievement of the CCG's objectives are understood and effectively managed
- ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed
- assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately

- protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and, if possible, elimination.

This Policy applies to all employees and contractors of the CCG.

All Senior Leads have a responsibility to incorporate risk management within all aspects of their work and that of their teams. All staff should be aware of the risks within their area of work and are required to comply with risk management processes.

Independent contractors are responsible for:

- Ensuring compliance with relevant legislation and best practice guidelines and for the development and management of their own procedural documents

- Independent contractors are required to demonstrate compliance with risk management processes which are compatible with this Policy.

2. Definitions

2.1 The Policy is based on the following definitions:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the CCG objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).

- **Risk Management** is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk.

- **Risk Assessment** is the process used to evaluate the risk and to determine whether precautions are adequate or more should be done. The risk is compared against predetermined acceptable levels of risk.

2.2 Further definitions of terms are set out in Appendix A.

3. Approaches to Risk Management: Principles, Aims & Objectives

The Policy sets out the CCG's approach to the way in which, in general terms, risks are managed. This will be achieved by having a thorough process of risk assessment in place. It will provide a useful tool for the systematic and effective management of risk and will inform and guide staff as to the way in which all significant risks are to be controlled.

3.1 **The policy will:**

- Ensure that risks to the achievement of CCG's objectives are understood and effectively managed.
- Describe how the CCG will maintain a risk management framework to assure the Governing Body that strategic and operational risks are being effectively managed
- Ensure that risk management is a cohesive element of the internal control systems within the CCG's corporate governance framework
- Ensure that risk management is an integral part of the CCG culture and its operating systems
- Ensure that the CCG meets its statutory obligations including those relating to health and safety and data protection
- Assure all stakeholders, staff and partner organisations that the CCG is committed to managing risk appropriately.

3.2 **To achieve this, the CCG is committed to ensuring that**:

- Risk management is embedded as an integral part of the management approach to the achievement of objectives
- Themes and trends will be identified patch wide and on an individual CCG basis via SIRMS and this will inform the management of risk
- The management of risk is seen as a collective and individual responsibility, managed through the agreed committee and management structures
- Patient feedback, complaints and staff feedback are used as an integral part of the approach to risk management
- Risk management support, training and development will be provided by the Commissioning Support Unit Governance Team.

4. Risk Management Framework

Whenever risks to the achievement of CCG's objectives have been identified, it is important to assess the risk so that appropriate controls are put in place to eliminate the risk or mitigate its effect. To do this, a standard risk assessment matrix is used, details of which are provided in the CCG's Risk Register Standard Operating Procedure aligned to this Policy.

This risk matrix is based on current national guidance which has been adapted to suit the CCG's agreed risk appetite.

Using this standardised tool will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

Risks are assessed in terms of the likelihood of occurrence/re-occurrence and the consequences of impact and an initial risk rating is applied. Controls and assurances are then identified in order to determine the residual risk rating. Where there are gaps in controls, an action plan should be developed.

4.1 There are four categories of risk:

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 6	Low risk
8 – 10	Moderate risk
12 – 16	High risk
20 – 25	Extreme risk

- **Extreme: 20-25** – the consequence of these risks could seriously impact upon the achievement of the organisations' objectives, its financial stability and its reputation. Examples include loss of life, extended cessation or closure of a service, significant harm to a patient(s), loss of stakeholder confidence, failure to meet national targets and loss of financial stability

- **Moderate-High: 12-16** – these are significant risks that require prompt action. With a concerted effort and a challenging action plan, the risks could be reduced within a realistic timescale

- **Moderate-low: 8-10 –** these risks can be reduced within a realistic timescale through reasonably practical measures, such as reviewing working arrangements, purchase of small pieces of new equipment, raising staff/patient awareness etc. These risks should be managed through the existing line management arrangements

- **Low** – these risks are deemed to be low level or minor risks which can be managed and monitored within the individual department

Once the category of risk has been identified, this will be entered onto the CCG's risk register. Please refer to 'section 7' below for further guidance on risk registers.

Any risk identified through the risk assessment process (or the incident reporting process), which the CCG is required legally to report, will be reported accordingly to the appropriate statutory body, e.g. Health and Safety Executive or Information Commissioner.

5. Risk Appetite

The CCG aims to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. However there is the recognition that by understanding the organisation's 'risk appetite', this will ensure the CCG supports a varied and diverse approach to commissioning.

Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. It can be influenced by personal experience, political factors and external events. Risks need to be considered in terms of both opportunities and threats and the consequent impact on the capability of the CCG, its performance and its reputation.

6. Risk Tolerance

Risk tolerance is the threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager. Any risks with a residual risk score of 6 should be added to the corporate risk register, which will be updated on a quarterly basis (or more frequently in the case of significant changes or new high risks). The full Risk Register will be presented to the Executive Committee and Audit and Assurance Committee 4 times per year and also to the Governing Body at intervals determined by the Governing Body (but at least twice a year). Any risks with a residual score of 12 or above should be escalated to the responsible CCG Executive Lead and immediately added to the CCG Assurance Framework in order for the Audit and Assurance Committee and Governing Body's attention to be drawn to these highly rated risks and their associated controls and assurances. Low risks will be managed and monitored at team level, any risks of concern (even if not scoring as a high risk) can be highlighted to the Audit and Assurance Committee for escalation to the Governing Body.

7. Risk Register

Current and potential risks are captured in the CCG's Risk Register and include controls, assurances and actions to manage the risks. The risk register is a log of risks that threaten the organisation's success in achieving its aims and objectives and is populated through the risk assessment and evaluation process. It is reported to the Executive Committee, Audit and Assurance Committee and the Governing Body. The Governing Body will be kept informed of changes to the Risk Register throughout the year – this will include receiving regular updates on risks that have an initial risk rating of 12+.

The CCG recognises the risk that fraud, bribery and corruption pose to its resources. This risk is included in the corporate (strategic) risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the CCG's counter fraud provider, AuditOne, as agreed in the counter fraud workplan and using their fraud risk planning tool. Regular meetings will be held between key CCG staff (i.e. CFO, Head of Corporate Services or Head of Governance etc.) and the AuditOne counter fraud specialist to review existing and emerging risks. Regular reports will be provided to the Audit and Assurance Committee to ensure effective monitoring of fraud, bribery and corruption risks.

The CCG's Risk Register SOP provides further detail and advice on the completion of risk registers and staff are supported with this by the CCG's Head of Corporate Services and Head of Governance.

8. Assurance Framework

The CCG will produce and maintain a Governing Body Assurance Framework. The Assurance Framework forms part of the overall governance arrangements of the CCG and is a key component of the organisation's internal control arrangements. The Assurance Framework forms a significant part of the assurance given by the Accountable Officer in the Annual Governance Statement and is in place throughout the year. In line with the Governing Body's agreed risk appetite and tolerance, risks with a residual scoring of 12 or above will be included on the Assurance Framework. It is reviewed by the Audit and Assurance Committee or equivalent and Governing Body. In addition, the Audit and Assurance Committee provides oversight as to the process in place relating to the Assurance Framework. The Assurance Framework will be reviewed by the Governing Body at least 2 times a year. The Governing Body will be kept informed of changes to the Assurance Framework throughout the year – this will include receiving regular updates on risks that have an initial risk rating of 12+.

Risks included on the Assurance Framework are also shared with other CCGs to facilitate benchmarking and sharing of good practice. In addition, the CCG will, where possible, participate in national Assurance Framework benchmarking exercises.

9. Implementation

This Policy will be available on the CCG's website and from the Head of Corporate Services and Head of Governance. All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

10. Training Implications

SIRMS training has been embedded across the CCG, additional refresher training is available when required via the CSU Governance team. Risk management support, advice and development sessions (either 1-1 or as teams) to be provided as required via the CSU Governance team tailored to CCG requirements. Training and development requirements continue to be considered by the CCG and the CSU to ensure a robust approach to risk reporting and management is maintained across the CCG.

11. Related Documents

11.1 Legislation and statutory requirements

- NHS England Risk Management Policy 2017
- NHS England Risk Management Framework 2019
- Health & Safety: Policy & Corporate Procedures NHS England 2015
- NHS England Business Continuity Management Framework 2016
- Data Protection Act 2018
- Data Security and Protection toolkit
- General Data Protection Regulation (GDPR) 2016.

12. Best Practice Guidance

- NHS Audit Committee Handbook (2018)
- The Healthy NHS Board: Principles for Good Governance (2013)
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054

13. Monitoring, Review and Archiving

13.1 Monitoring

The CCG and the CSU will review the Policy in accordance with the specified review date, unless legislation or new guidance to ensure it continues to be compliant with good practice.

Risk Management assurance will be reported to the appropriate CCG Committee via the Governance Assurance and Risk Report.

The CCG's internal auditors carry out an annual audit of governance and risk management. The effectiveness of the CCG's controls in relation to risk is considered as part of this audit, the outcome of which is reported to the Audit and Assurance Committee.

13.2 Review

The Governing Body will ensure that this Policy document is reviewed in accordance with the specified review date. No Policy will remain operational for a period exceeding two years without a review taking place.

Staff who become aware of any change which may affect the Policy should advise the CCG lead (Head of Corporate Services or Head of Governance) who will then consider the need to review the Policy or procedure outside of the agreed timescale for revision. For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the Policy must always follow the original approval process.

13.3 Archiving

The Governing Body will ensure that archived copies of superseded Policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016

Appendix A

Further Definitions

- **Action plan**
  How the identified gap is to be addressed and how the risk is to be diminished.

- **Assurance Framework (AF)**
  The AF is an integral part of the system of internal control and defines the significant potential risks which may impact on delivery of the organisation priorities. It also summarises the controls and assurances that are in place, or are planned, to mitigate against them. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the governing body to develop and subsequently monitor an assurance action plan for closing the gaps.

- **Consequence**
  This is a numerical value from one to five (five = catastrophic) for the impact that a risk may have on the organisation or individual, and may be physical, financial, reputational etc.

- **Control**
  The control of risk involves taking steps to reduce the risk from occurring such as application of policies or procedures.

- **Corporate risks**
  Risks to operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues including risks relating to business continuity and security of information.

- **Risk register**
  The risk register is a summary of the risks identified through internal processes.

- **Environmental including health and safety**
  Ensuring the wellbeing of staff and visitors whilst using our premises.

- **External assurance**
  External evidence that risks are being effectively managed (e.g. planned or received audit reviews).

- **Financial risk**
  Associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme.

- **Gaps in controls or assurances**
  Where an additional system or process is needed, or evidence of effective management of the risk is lacking.

- **Impact**
  A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.

- **Issue**
  A relevant event that has happened was not planned and requires action. It can be any concern, query and request for change.

- **Likelihood**
  A measure of the probability that the predicted harm, loss or damage will occur. This is a numerical value from one to five (five = almost certain) for the potential of the risk to be realised.

- **Management assurance/actions**
  What are we doing to manage the risk and how this is evidenced?
  Sources of information used to ascertain whether controls are working or not. Examples include minutes of meetings, internal or external audit reports, survey results and Committee reports.

- **Operational risks**
  A risk that impacts on operational achievement. Operational risks are managed locally within the directorate and are the responsibility of the appropriate Director /Senior Manager.

- **Reputational risks**
  Associated with quality of services, communication with public and staff, patient experience.

- **Risk appetite**
  The organisation's unique attitude towards risk taking that, in turn, dictates the amount of risk that it considers is acceptable.

- **Residual risk**
  The risk remaining after the risk response has been applied.

- **Risk**
  An uncertain event or set of events that, should it occur, would have an effect on the delivery of objectives. It is measured in terms of consequence and likelihood.

- **Risk assessment**
  The process used to evaluate the risk and to determine whether precautions are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk.

- **Risk management**
  The systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk.

- **Risk owner**
  A named individual who is responsible for the management, monitoring and control of all aspects of a particular risk assigned to them.

- **Risk tolerance**
  The threshold level of risk exposure which, when exceeded, will trigger an escalation to bring the situation to the attention of a senior manager. Any risks scored as 12 or above should be escalated to a senior manager for review and monitoring at the Executive Committee.

- **Strategic risks**
  A significant risk that has the potential to impact across the organisation. These risks have been mapped to the objectives and will be presented to the Governing Body in the Assurance Framework.

Appendix B

Schedule of Duties and Responsibilities

Council of Members	The council of members has delegated responsibility to the Governing Body (GB) for setting the strategic context in which the organisational process documents are developed and for establishing a scheme of governance for the formal review and approval of such documents.
Governing Body	The Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Governing Body discharges this duty as follows: • Identifies risks to achievement of its strategic objectives • Identifies risks associated with transitional arrangements • Monitors these via the Assurance Framework • Ensures that there is a structure in place for the effective management of risk through the CCGs • Ensures a process is in place for the review and approval of the Risk Management Policy. • Demonstrates leadership, active involvement and support risk management.
Executive Committee	Members of the Executive Committee will: • Maintain awareness of the main risks facing the organisation • Take ownership where relevant of principal (strategic) risks that pose a threat to the achievement of strategic objectives and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates to the Governing Body Review the Risk Register • Take or delegate ownership, where relevant, of risks that pose a threat to the achievement of objectives or the business of the CCG and ensure appropriate action is taken to mitigate and manage risks ensuring regular updates are added to the risk register • Ensure the processes for managing risk within the CCG are clearly understood, appropriately delegated and effective.
Audit & Assurance Committee	The Audit & Assurance Committee has overall responsibility for overseeing the implementation of this Policy and will: • Review all risks on the corporate risk register and monitor progression of stated action on a quarterly basis. Ensure the established processes to manage risk is in place and provide support for action where necessary • Ensure the processes for managing risk within the CCG are clearly understood, appropriately delegated and effective. Escalate issues to the governing body as appropriate, in particular the identification of new, significant risk or areas of concern of risks graded high or moderate high to the Governing Body.
Responsible Directors	CCG Leads will: • Be familiar with the main risks in their area of activity, leading the management of risks where required • Ensure the processes for managing risk within services/teams are clearly understood by managers, appropriately delegated and effective • In conjunction with the Head of Corporate Services / Head of Governance and staff within their own directorate, determine the level of risk and required actions to eliminate or control the level of risk.

Risk owners	Responsible for managing individual risks and providing updates on the management of those risks and identifying and carrying out action plans to mitigate risks.
All Staff	Risk management is everybody's responsibility and all staff must be familiar with the main risks in their area of activity
CSU Staff	Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures of their employing organisation.

Appendix C

Equality Impact Assessment Screening

Step 1

As a public body organisation we need to ensure that all our strategies, policies, services and functions, both current and proposed have given proper consideration to equality and diversity, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership, Carers and Health Inequalities).

A screening process can help judge relevance and provides a record of both the process and decisions made.

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Julie Rutherford
Role: Senior Governance Officer NECS

Title of the service/project or policy:

C014 – Risk Management Policy

Is this a:

☑ Strategy / Policy ☐ Service Review ☐ Project

If other, please specify:

What are the aim(s) and objectives of the service, project or policy:

This policy aims to set out the Tees Valleys CCG's approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services. In addition, the adoption and embedding within the organisation of an effective risk management policy and processes will ensure that the reputation of the CCG is maintained and enhanced, and its resources are used effectively to reform services through innovation, large- scale prevention, improved quality and greater productivity.

Who will the project/service /policy / decision impact?

Consider the actual and potential impacts:

- [✓] Staff
- [✓] service users/patients
- [✓] other public sector organisations
- [ ] voluntary / community groups / trade unions
- [ ] others, please specify:

Questions	Yes	No
Could there be an existing or potential impact on any of the protected characteristic groups?	Yes	
Has there been or likely to be any staff/patient/public concerns?	Yes	
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	Yes	
Could this piece of work affect the workforce or employment practices?	Yes	
Does the piece of work involve or have an impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations	Yes	

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document.

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Debra Elliott	Deputy Head of Governance & Business Manager NECS Organisational Development & Corporate Services Directorate	

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Equality Impact Assessment

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment. This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

Step 2 Evidence Gathering

Name of person completing EIA: Julie Rutherford – Senior Governance Officer
Title of policy/strategy/guidance: CCG CO14 Risk Management Policy
Existing: √ New/proposed: □ Changed: □
What are the intended outcomes of this policy/service/process? **Include outline of objectives and aims.** The purpose of this policy is to provide a support document to enable staff to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the normal business. The Policy sets out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the CCGs for timely, efficient and cost-effective management of risk at all levels within the organisation. The Policy aims to: • To ensure that risks to the achievement of the CCG's objectives are understood and effectively managed • To ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed • To assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately.
Who will be affected by this policy/strategy /guidance? (please tick) √ Consultants √ Nurses √ Doctors √ Staff members √ Patients √ Public □ Other If other please state:

Current Evidence/Information held	Outline what current data/information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	CCG workforce data  Workforce data.docx

Step 3 Full Equality Impact Assessment

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful.
Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:

Age
A person belonging to a particular age

There is no impact on any staff member belonging to a particular age group.

Should risk training be required for this policy each CCG has accessible venues with good IT facilities for presentations with several screens placed within each room.

Disability
A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

Positive impact, risks will be reviewed and actions will be put in place to mitigate any further risk. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The policy will be made available via the CCG's intranet and will also be made available in other formats where required, such as Braille, Audio, easy read etc.

Communications should be available in a range of formats for people with sensory and learning disabilities, e.g. Braille, audio, video, Easy Read etc., to ensure engagement in an exclusive way.

Arrangements would be made for venues that are accessible to all e.g. ramps for wheelchairs, disabled toilets, hearing loops, signing, interpreters/translators (where requested).

Should risk training be required for this policy each CCG has accessible venues with good IT facilities for presentations with several screens placed within each room.

Gender reassignment (including transgender) and Gender Identity
Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.

Positive impact, staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of the policy does not include vocabulary that should cause offense.

Marriage and civil partnership
Marriage is defined as a union of a man and a woman or two people of the same sex as partners in a relationship. Civil partners must be treated the same as married couples on a wide range of legal matters

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this policy does not negatively impact on marriage and civil partnership.

Pregnancy and Maternity
Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this policy does not negatively impact on pregnancy and maternity.

Should risk training be required consideration will be made to those on maternity/paternity leave to ensure they are included when they return to work.

Race
It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of the policy does not include vocabulary that should cause offense.

The policy can be made available in other languages, interpreters can also be made available if applicable.

Religion or Belief
Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The content of this policy does not negatively impact on religion or belief and does not include vocabulary that should cause offense.

Sex/Gender
A man or a woman.

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The policy has no impact on sex/gender and does not discriminate between males and females.

Sexual orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

The policy uses appropriate language and does not negatively impact on sexual orientation.

Carers *A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required. Should risk training need to be provided consideration will need to be made to those with carer responsibilities to ensure that consideration is given to part time working as well as caring responsibilities.
Other identified groups relating to Health Inequalities *such as deprived socio-economic groups, rural areas, armed forces, people with substance/alcohol abuse and sex workers.* *(Health inequalities have been defined as "Differences in health status or in the distribution of health determinants between different population groups."* *Health inequalities can therefore occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical locations.)*
Positive impact, an associated risk can be reported and managed should it occur. Staff can get assistance to report and manage a risk from the NECS Governance Team if required.

Step 4 Engagement and Involvement

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics?
SIRMS users and CCG Committee Members - via bulletins, communications, training sessions and contact with members of the NECS Governance Team who are always contactable for help and assistance.
If no engagement has taken place, please state why:

Step 5 Methods of Communication

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☑ Verbal – through focus groups and/or meetings ☑ Verbal - Telephone ☐ Written – Letter ☑ Written – Leaflets/guidance booklets ☑ Email ☑ Internet ☑ Other
If other please state: Via SIRMS (Safeguard Incident and Risk Management System)

Step 6 Potential Impacts Identified – Action Plan

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
NA		All	Risk Management Training to staff and incident managers to promote quality of risk reporting & data.	Positive - increased awareness of process and support on offer.	**JR**	**Ongoing**

Sign off

Completed by:	Julie Rutherford Senior Governance Officer
Date:	14.10.2019
Presented to: (appropriate committee)	Executive Committee
Publication date:	October 2020