INTEGRATED RISK MANAGEMENT FRAMEWORK 2018 – 20

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Contents

Integrated Risk Management Framework

1 Introduction

NHS Barnsley Clinical Commissioning Group (the CCG) is committed to actively managing risks wherever possible. This includes minimising risks to our patients, staff, members of the public and other stakeholders.

The CCG will establish an organisational culture to ensure that risk management is an integral part of everything we do. Risk management is a key part of all management systems, corporate planning and is an integral part of our business. Effective risk management will help us to deliver our objectives.

The Integrated Risk Management Framework defines the way in which the CCG will manage all risks to the organisation in order to:
- Enable it to fulfil its statutory and regulatory obligations
- Ensure that systems of control are in place to minimise the impact of all types of risk
- Ensure as far as is reasonably practicable minimal harm comes to those individuals to whom the Trust owes a duty of care.

The CCG has adopted The Risk Management Standard (AS/NZS 4360:1999) which defines risk as:

"The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood".

Good risk management awareness and practice at all levels is a critical success factor for any organisation. Risk is inherent in everything that the CCG does: commissioning healthcare, assessing patients, determining service priorities, managing a project, purchasing, managing finances, investing in equipment, deciding about future strategies, or even deciding not to take any action.

This framework forms part of a suite of policies which underpins NHS Barnsley Clinical Commissioning Group's approach to Governance and the management of risk and should be read in conjunction with the policies identified above.

2 Purpose

The purpose of this framework is to ensure consistency of approach across NHS Barnsley Clinical Commissioning Group in the management of risk.

The CCG attaches great importance to the management of all risks that may be faced by patients, staff, members of the public and other stakeholders. The Clinical Commissioning Group is fully committed to the principles of risk management. It is therefore essential that all staff work together to achieve an environment compatible with the commissioning of high quality safe care for patients but also to protect the assets and resources of the organisation and reduce to a minimum the risks of personal injuries to staff and others.

The quality of care commissioned and delivered and the promotion of health are vital elements in both the vision and values that NHS Barnsley Clinical Commissioning Group and its staff embody. The CCG's vision is:

"We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first".

The CCG's values encapsulate the beliefs that are shared among the stakeholders of the organisation. These will drive the culture and priorities and provide a moral framework in which decisions are made.

NHS Barnsley Clinical Commissioning Group has the following values:

- Equity and fairness
- Services are designed to put people first
- Services are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients

Effective risk management as defined within this framework will support the organisation in meeting its vision and values.

2.1 Aims Objectives and Outcomes

The aims, objectives and benefits of the implementation of this framework are as follows:

Aims

- To manage all risks by processes which ensure scarce resources are allocated to management of the greatest risks;
- To secure the full involvement of all staff in identifying and managing risk;
- To establish risk management as an integral part of operational and service planning processes.

Objectives

- To protect the interests of patients, public, internal and external stakeholders and staff;
- To ensure compliance with legislative and statutory requirements;
- To progressively identify risk by regular and systematic review and audit;
- To foster a safe no blame environment where staff are encouraged to report risks, incidents and near misses;
- To ensure the required level of resource and investment in the risk management process is available;
- To protect the assets and interests of NHS Barnsley Clinical Commissioning Group;

- To preserve and enhance NHS Barnsley Clinical Commissioning Group's reputation particularly in relation to risk management.

Outcomes

- Provide assurance to public, staff, regulatory authorities and other stakeholders that risks are being managed pro-actively;
- Reduction in harm to both patients in commissioned services and staff;
- Available resources to manage risks are used effectively;
- Resources required to deal with litigation are minimised.

This framework relates to the management of the risks faced by NHS Barnsley Clinical Commissioning Group and therefore, primarily relates to the resources that we directly manage. However, the activities of commissioned services, primary care practitioners, and the actions of organisations outside NHS Barnsley Clinical Commissioning Group, but acting on its behalf, involve risks which can have an impact on the delivery of NHS Barnsley Clinical Commissioning Group objectives. To this extent their activities and actions come within the scope of this framework.

By implementing an organisation wide process of risk management, all staff will be encouraged to identify potential hazards and risks and feel free to report incidents and near misses knowing that they do so in a just and equitable culture.

The Governing Body needs to have assurance that the risks of the organisation are managed in a systematic, robust way to ensure high quality cost effective patient care.

2.2 Features and Benefits of a Risk Management System

- Regular reporting of risks to the Governing Body.
- A common, compatible approach to risk assessment Single incident reporting system.
- Consistent incident investigation arrangements.
- Risks recorded in the Assurance Framework and / or Risk Register.
- Unified risk management training and records of attendance.
- Single library of evidence to demonstrate the effectiveness of the Risk Management System.
- Learning lessons from patient experience, incidents, claims, complaints, and feedback to staff.

The successful implementation of the Framework will lead to the following benefits:

- Protect the services, reputation and finances of the organisation through a process of risk identification, assessment, control, elimination or transfer.
- Optimise the resources available for patient care by managing risk and thus reducing the financial implications associated with adverse incidents.

- Identification and control, by way of elimination or reduction to an acceptable level, of all risks which may adversely affect:

  o The quality of commissioned services.
  o The health, safety and welfare of patients, visitors and staff.
  o The ability of the organisation to provide services/functions.
  o The ability of the organisation to meet its legal and contractual commitments.

The Framework will ensure that the CCG is never knowingly exposed to a risk which has not been identified, and that it understands those risks, and is aware of the potential cost of the risk.

2.3 Assurance

Assurance is the confidence in the efficiency and effectiveness of the organisation's policies, processes and operations to deliver the organisation's objectives and comply with statutory obligations. This is delivered through the provision of accurate and current information to the Governing Body and the associated Committees.

The Governing Body can only properly fulfil its responsibilities if it has a sound understanding of the principal risks that it faces.

2.4 Governance

Governance is the process by which the Governing Body assures itself that the control measures in place to identify and manage risks of all kinds are effective.

This assurance may be from internal or external sources. The Governing Body Assurance Framework (GBAF) is the main document that supports the Governing Body in the monitoring of its annual commissioning plan objectives and principal risks associated with achieving them.

The Risk Register provides an ongoing identification and monitoring process of strategic or operational risks that may adversely impact on the delivery of the CCG's objectives or Commissioning Plan. The Governing Body will determine processes of assurance. This will be demonstrated on the Assurance Framework and Risk Register. Any risks that could affect the CCG's ability to deliver its objectives will be escalated to the Assurance framework as a gap in control or assurance.

2.5 The Governing Body Assurance Framework

The Governing Body Assurance Framework is a high level report which enables the Governing Body to demonstrate how it has identified and met its assurance needs focussed on the delivery of its objectives through the Annual Commissioning Plan.

The Assurance Framework is the means by which the Governing Body:

- Holds itself to account
- Affirms that assurance is in place, and
- Clarifies what risks will compromise strategic objectives.

The Governing Body's Audit Committee will review the establishment and maintenance of an effective system of governance, internal control and risk management across the CCG for both clinical and non clinical activities, including partnerships that support the achievement of the organisation's objectives.

The GBAF provides the Governing Body with assurance that they have effective systems of internal control, capable of:
- identifying risks relating to the achievement of objectives
- evaluating the nature and extent of those risks, and
- managing them efficiently, effectively and economically.

Further clarity of the definitions can be found in Appendix 1.

3 The risks of not having this framework in place

Failure to comply with this Framework may result in the following corporate risks arising:

- The CCG may not achieve its principal objectives
- The safety of patients, staff, contractors and members of the public may be compromised
- The CCG may not meet its statutory and mandatory risk management obligations
- The CCG may not have in a place a sound system of internal control to manage risk.
- The CCG could be subject to litigation and claims.
- The CCG may not deliver its functions economically, efficiently, and effectively.

4 Definitions

4.1 Risk Management

Risk Management may be defined as the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. The systematic application of management polices procedures and practices to the tasks of establishing the context of identifying analysing, evaluating, treating, monitoring and communicating risk. (Adapted from the Australian/New Zealand standard AS/NZS 4360:1999) This standard has been adopted by the NHS. Legislation and Standards in relation to Health & Safety are specifically identified within the Health & Safety Policy.

4.2 Risk

Risk is the chance that something will happen that will have an impact on achievement of NHS Barnsley Clinical Commissioning Group's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring) (adapted from the Australian/New Zealand standard AS/NZS 4360:1999)

4.3 All Risks

The management of risk in NHS Barnsley Clinical Commissioning Group will cover the entire risk portfolio across the organisation, including Corporate, Clinical, and Non-Clinical risks associated with the delivery of the Commissioning Plan and the CCG's statutory duties.

4.4 Financial Risk

Financial risk can be defined as any function or process of the organisation that involves the management of finances and which could result in an adverse outcome.

4.5 Acceptable / Unacceptable Risk

Many risks within the organisation are complex in terms of impact. These risks need quantifying using the methodology of a 5 x 5 Risk Assessment matrix (see Appendix 2). The reasons for this are to ensure that all risks are compared objectively. These risk "scores" will be prioritised on the NHS Barnsley Clinical Commissioning Group Risk Register.

RAG	Score	Risk description	Managerial Action
	1 - 3	Low risk	Can be managed locally by routine controls.
	4 - 6	Moderate risk	Managed locally with individual risk treatment plans
	8 - 12	High risk	Senior Management attention required. Detailed planning and controls
	15 - 25	Extreme risk	Immediate action Chief Officer or nominated Deputy level management

The Governing Body's risk tolerance (appetite under which risks can be tolerated) is a score of 12 or below where the assessment has been undertaken following the implementation of controls and assurances. This will be the same for both the Assurance Framework and Risk Registers. Scores of 15 or higher would be considered as an unacceptable risk and would be monitored directly by the Governing Body. Scores of less than this will be managed appropriately at a lower level in the CCG.

All risks scoring 15-25 (extreme risk) will be notified to every meeting of the Governing Body. The full Assurance Framework will be presented to the Governing Body 3 times per year and the full Risk Register twice a year.

5. Principles

NHS Barnsley Clinical Commissioning Group must have a Risk Management Framework to ensure that all risks to the organisation are identified analysed, controlled and managed in a corporate way leading to a sound system of internal control.

5.1 Structured Approach

For risk management to be truly effective in terms of mitigating the effects of risks and in providing a productive return on investment of resources, it needs to be applied in a structured and standardised way across the CCG.

The model for risk management to be used in the organisation will be adapted from the Australian Risk Management Standard AS/NZS 4360:1999. The main principles are as follows but are further defined at Section 7 Procedure.

NHS Barnsley Clinical Commissioning Group will have the following in place:

- Risk assessment, control and escalation processes
- Governing Body Assurance Framework, and
- Risk Register.

5.2 Commissioning and Business Planning

NHS Barnsley Clinical Commissioning Group plans to commission modern, professional, high quality and safe services for the people of Barnsley. The plan for achieving this is documented in the Barnsley Health and Wellbeing Strategy and the NHS Barnsley CCG Strategic Commissioning Plan.

The CCG intends to fully contribute to the Government's wider agenda for change and modernisation in the NHS. The Governing Body therefore embraces risk management in its broadest sense as an effective system for maximising opportunities and reducing the negative impact of risks on the organisation's ability to meet its corporate objectives.

The Governing Body is committed to the effective implementation of risk management throughout the organisation, in accordance with this Framework, and will review its effectiveness as part of its planning.

Risk management activities will be included in the NHS Barnsley Clinical Commissioning Group planning process to identify the level of resources required. The development of the risk register will allow prioritisation of risk treatments to support decisions made in the allocation of funding.

5.3 Appropriate Competencies

The CCG will ensure that staff leading risk management processes have the appropriate skills and training to perform their tasks.

5.4 Infrastructure

The CCG acknowledges that, in addition to planning and corporate expenditure on risk treatments, financial and other resources may be needed at a local level to ensure the effective implementation of the risk management system.

6. Roles and Responsibilities

To ensure risk management is integrated into the management practice and culture of NHS Barnsley, there needs to be clear lines of accountability throughout the organisation for risk management.

Accountability arrangements will define the risk management relationships between the Membership Council, Governing Body, Committees, Managers and Staff.

The key bodies and individuals within the CCG who have responsibility for Risk Management are set out below.

6.1 Responsibility of the Governing Body

NHS Barnsley Clinical Commissioning Group has in place systems and processes to assure the Governing Body that risk is being managed locally and there are reporting structures in place to do this. The Audit Committee oversees the risk management function and ensures that systems of internal control exist and are functioning correctly.

The Governing Body on behalf of the Membership Council ensures that the organisation consistently follows the principles of good governance applicable to the NHS organisation. This includes the oversight and development of systems and processes for financial control, organisational control, clinical governance and risk management, however there are currently in place a number of these processes which will develop and mature over time.

The Governing Body assesses strategic, corporate, clinical, non-clinical and financial risks against the organisation's objectives via the NHS Barnsley Clinical Commissioning Group Assurance Framework.

6.2 Accountability and Responsibility

6.2.1 Chief Officer

- The Chief Officer has the overall responsibility for risk management and is vicariously liable for the acts and omissions of all the CCG's

employees, (whilst acting in the course of NHS Barnsley Clinical Commissioning Group employment).

- The Chief Officer has overall responsibility for having an effective risk management system in place within the organisation, for meeting all statutory requirements and for adhering to guidance issued by the Department of Health in respect of Corporate Governance;
- The Chief Officer is responsible for ensuring the creation, implementation of this strategy and its regular review;
- The Chief Officer is required to have in place an effective system of risk management and internal control and to sign the Annual Governance Statement;
- The Chief Officer is responsible for ensuring all Managers have measurable personal objectives including risk management as appropriate.

6.2.2 Senior Managers

All Senior Managers are responsible and accountable for:

- The effective management of risk within their area of responsibility, including assurance that appropriate controls are in place and that any standards are being monitored;
- Using a NHS Barnsley Clinical Commissioning Group wide methodology to
  - Identify and assess risk
  - Implement effective risk treatments
  - Report risk in accordance with the Integrated Risk Management Framework (including reporting risks for inclusion on the Risk Register);
- Ensuring all managers and staff under their management control, are aware of the Integrated Risk Management Framework and of their responsibility for implementation;
- Ensuring Risk Action Plans are produced within their area of responsibility;
- Ensuring adequate governance systems and processes are present within their area of responsibility;
- Reviewing   monthly the risks for which they have responsibility for and more often depending on the risk;
- Ensuring robust systems are in place for appropriate feedback to staff;
- Ensuring that staff attend mandatory training in relation to risk as defined by the organisation.

6.2.3 Lay Members

Lay Members have particular Risk Management responsibilities and are members of the following sub-committees:

6.2.4 Audit Committee:

The Audit Committee is chaired by the Lay Member for Governance and attended by the Lay Member for Patient and Public Engagement and Primary Care.

All Audit Committee members have a responsibility to review the Integrated Risk Management Framework via reports to the Audit Committee and Governing Body

6.2.5 Quality and Patient Safety Committee

The Quality and Patient Safety Committee has the Lay Member for Public and Patient Engagement and Primary Care Commissioning as part of its membership.

6.2.6 Finance and Performance Committee

The Chair of the Audit Committee (Lay Member for Governance) is a member of the Finance and Performance Committee.

6.2.7 Equality and Engagement Committee

The Equality and Engagement Committee is chaired by the Lay Member for Patient & Public Engagement and Primary Care Commissioning.

6.2.8 Primary Care Commissioning Committee

The Primary Care Commissioning Committee is chaired by the Lay Member for Public Engagement and Primary Care. The Lay Member for Governance and the Lay Member for Accountable Care are also members.

6.3 Responsibilities of Specific Managers and Competent Officers

Chief Officer

The Chief Officer has overall responsibility for:

- Corporate Governance, and Corporate Risks;
- Health and Safety Management, Fire Safety and Security;
- Estate and Equipment Risk Management.

Chief Nurse

The Chief Nurse has the responsibility for:

- The management of Complaints and Serious Incidents;
- Clinical Risk Management;
- Infection prevention and control;

- To be the Accountable Officer in relation to controlled drugs;
- Equality and Diversity
- Safeguarding Children
- Safeguarding Adults
- To act as the CCG's Caldicott Guardian.

Chief Finance Officer

The Chief Finance Officer has the responsibility for the implementation of Financial Risk Management.

Head of Governance and Assurance

The Head of Governance and Assurance has the responsibility to:

- Provide leadership to the Corporate Governance agenda;
- Operationalise, monitor and maintain the Risk Register and Assurance Framework;
- Be the Senior Information Risk Owner (SIRO) and ensure systems and processes are in place to manage Information Governance Risks;
- Review and update the Integrated Risk Management Framework on a three yearly basis or earlier to meet any new requirement or statutory, mandatory and good practice standards.

Medical Director

The Medical Director has the responsibility to support the Clinical Commissioning Group in the commissioning of safe, high quality services from all providers ensuring the best possible experience for patients, specifically with regard to:

- Providing and quality assuring clinical advice;
- Addressing professional performance issues (responding to service failure, complaints, untoward incidents and (working with the Local Area Team) poor performance in primary care)

6.4 Managers

Are responsible for:

- Ensuring Risk Management policies and procedures are implemented consistently within their area of responsibility;
- Fostering a supportive environment to facilitate the reporting of risks and incidents;
- Ensuring that the risk register for their area of responsibility is populated in line with the Risk Assessment policy and procedure;
- Keeping staff informed of the risks faced by the CCG and what is being done to treat the risks;

- Ensuring staff under their management have access to opportunities for training and development including attendance at mandatory risk management training events;
- Following up non-attendance at induction and mandatory training.

6.5   All Staff

Have a responsibility for:

- Working to NHS Barnsley Clinical Commissioning Group policies and procedures;
- Maintaining safe systems of work;
- Taking care of their own safety and that of their colleagues and all other persons who may be affected by their actions or omissions;
- Taking care of the buildings, equipment and other assets;
- Reporting risks, incidents and near misses and taking remedial action in accordance with Risk Management policies and procedures;
- Undertaking all necessary statutory and mandatory training;
- Meeting professional registration requirements, including those relating to Continuing Professional Development.

6.6   Cross Trust working, Voluntary Sector, Interagency working

In consultation with other agencies, including other Trusts, Clinical Commissioning Groups, Local Authority, Independent Sector and the voluntary sector a framework for implementation and support will be developed to promote risk management, training and governance issues. There needs to be clarity regarding roles, responsibilities and accountability in relation to risk management. A statement of assurance compliance may need to be in place.

6.7   Organisational Arrangements

A number of sub committees and groups support the risk management agenda. Within the governance arrangements for NHS Barnsley Clinical Commissioning Group there are a number of committees which support the Governing Body. Their roles are identified below.

Audit Committee

The Committee provides assurance and advice to the Governing Body on the entirety of the CCG's control and integrated governance arrangements. This includes the proper stewardship of resources and assets, including value for money; financial reporting; the effectiveness of audit arrangements (internal and external); and risk management arrangements. The Audit Committee also receives reports from the Health and Safety and Business Continuity Group established in order to provide the statutory consultation forum required of the organisation for all Health and Safety and Business Continuity matters.

Quality & Patient Safety Committee

The Committee advises the Governing Body with a view to ensuring that effective quality arrangements underpin all services commissioned on behalf of the CCG, regulatory requirements are met and safety is continually improved to deliver a better patient experience. The Committee receives and considers information in relation to complaints and serious incidents in commissioned services and within the CCG to ensure that all necessary action is being taken.

Quality & Patient Safety Committee also has overall responsibility for Information Governance, including oversight of the CCG's procedures for ensuring it meets at least the minimum requirements necessary under the Information Governance Toolkit.

Finance and Performance Committee

This Committee advises and supports the Governing Body in scrutinising and tracking of key financial and service priorities, outcomes and targets.

Remuneration Committee

The Committee advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; and provisions for other benefits and allowances under any pension scheme.

Equality and Engagement Committee

The Committee provides advice to the Governing Body on communication and patient, carers and public engagement, ensuring that Patient and Public Engagement is central to the business of the CCG.

The Committee also advises the Governing Body to ensure that effective systems are in place to manage and oversee the implementation of a strategic vision for equality, diversity and human rights, both within the CCG, and across all services commissioned on behalf of the CCG, in order to ensure compliance with statutory duties in relation to equality and diversity.

Primary Care Commissioning Committee

Makes collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee manages the delegated allocation for commissioning of primary care services in Barnsley, and provides assurance to the Governing Body that the functions delegated to the CCG have been appropriately discharged, with regard to outcomes for patients, the management of any conflicts of interest, primary care procurement and contract management, and the availability of services. The Committee also has delegated authority from the Governing Body to take

procurement decisions where Governing Body is unable to do so owing to conflicts of interest.

Information Governance Group

The Information Governance (IG) Group provides assurance to the Quality and Patient Safety Committee that NHS Barnsley CCG is compliant with relevant law, external accreditations, mandatory regulation and guidance in relation to information governance. It leads on, and manages, IG on a day to day basis. It oversees the broader information governance agenda puts in place systems and processes to ensure the CCG maintains a co-ordinated approach to IG that delivers a high standard of service.

QIPP Delivery Group

The QIPP Delivery Group will be the focal point for managing the projects that collectively comprise the CCG's QIPP programme. It will both support and hold to account clinical leads, management and project leads responsible for the delivery of QIPP projects and provide assurance to the Finance and Performance Committee on the delivery of the QIPP programme as a whole

Health & Safety & Business Continuity Group (ToR)

The Health and Safety and Business Continuity Group has been established in accordance with Barnsley CCG's Health and Safety Policy. Reporting to the Audit Committee, the Group will oversee and coordinate the operational implementation of the CCG's Health and Safety, Fire Safety, Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policies to ensure compliance with relevant standards and legislation

Primary Care Quality Improvement Group

The purpose of the group is to seek a clear, comprehensive understanding and assurance about the quality of primary care services in Barnsley in order to identify best practice and potential areas for improvement and escalating any issues of concern in line with the Primary Care Quality Monitoring Process to the Quality and Patient Safety Committee. The group will escalate any concerns relating to contracting or GP performance to the Primary Care Commissioning Committee

Health Protection Board

The aim of the Health Protection Board is to provide assurance to Barnsley Metropolitan Borough Council, Barnsley Clinical Commissioning Group and the Barnsley Health and Wellbeing Board about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.

The Board is chaired by BMBC's Director of Public Health and the membership includes senior representatives from the CCG, both its main providers, Public Health England, and NHS England's Area Team.

Barnsley Safeguarding Adults Board

The Board is responsible for leading safeguarding arrangements across the borough and for overseeing, coordinating and challenging the effectiveness of the work of its members and partner agencies. NHS Barnsley Clinical Commissioning Group will co-operate and support the Local Authority in the operation of Safeguarding Adults Board. NHS Barnsley Clinical Commissioning Group has membership of this multiagency Board. In addition NHS Barnsley Clinical Commissioning Group has designated and named professionals to support the delivery of the safeguarding agenda. There are a number of policies and procedures in place across the borough to support the system of safeguarding which all staff will follow.

Children Safeguarding Board

The Safeguarding Board has the purpose of safeguarding and promoting the welfare of children within the Borough and a constitution is in place for this. NHS Barnsley Clinical Commissioning Group will co-operate and support with the Local Authority in the operation of the Local Safeguarding Children. NHS Barnsley Clinical Commissioning Group has membership of this multiagency Board. In addition NHS Barnsley Clinical Commissioning Group has designated and named professionals to support the delivery of the safeguarding agenda. There are a number of policies and procedures in place across the borough to support the system of safeguarding which all staff will follow.

6.8 Job Descriptions

Where appropriate staff will have explicit risk management objectives within their job descriptions and as part of the appraisal process they will have Personal Development Plans that are regularly reviewed and acted upon.

6.9   Staff Side

Staff side will maintain their knowledge of the CCG's policies and procedures for risk management and will encourage and support staff to comply, eg through reporting incidents in accordance with the CCG's incident reporting policy.

7. Procedure

7.1 Risk Management Process

Risk Management is a proactive systematic process of risk identification, analysis, treatment and evaluation of potential and actual risks. The primary purpose of Risk Management is to enable individuals and the CCG to deal competently with all key risks, thereby providing more confidence that personal and organisational objectives will be achieved and that statutory requirements placed upon the CCG will be complied with.

Through the implementation of this strategy and appropriate training, it is anticipated that staff will develop a deeper understanding of the breadth of their statutory duties of care. This should lead to staff feeling confident in identifying potential risks and in reporting incidents and near misses, freely participating in audits and peer reviews and having ownership of policies, procedures and guidelines. Managers in particular should appreciate the value of their contribution to risk management through implementing the risk assessment process within their area.

7.2 Governing Body Assurance Framework

NHS Barnsley Clinical Commissioning Group will have in place a Governing Body Assurance Framework. This Assurance Framework will only contain risks mapped to the strategic principal objectives and priorities. The main purpose of the Assurance Framework is to act as a tool which the Governing Body can use to obtain assurance on the achievement of NHS Barnsley Clinical Commissioning Group's principal objectives and priorities. The Assurance Framework is intended to provide reasonable assurance to the CCG that the principal risks to these objectives and priorities are being managed effectively. The Governing Body will receive a summary of the GBAF, and details of risks rated as extreme, at every meeting. It will also receive the full Assurance Framework at least three times a year.

7.3 NHS Barnsley Clinical Commissioning Group Risk Register

The Risk Register will only contain the current risks facing the organisation including risks in the Assurance Framework for which there are gaps in control or assurance. The rationale for this being that where there are gaps either in control or assurance in the framework that then becomes a current risk to the organisation.

Risks recorded on the Risk Register will be allocated to a Committee. The responsible Committee will receive an extract of the Risk Register for review at each of its meetings. The responsible Committee will ensure there are appropriate mitigating actions in place; that the risk is appropriately described and scored; and that extreme risks are escalated to the Assurance Framework as gaps in control or assurance (see 7.4 below). Red and amber risks should be reviewed at every meeting, and other risks should be reviewed at least twice a year.

7.4 Escalation and Interaction Process

It is important that there is interaction and escalation between the Assurance Framework and the Risk Register so that for example any gaps in control identified in the Assurance Framework can be fed into the Risk Register for a risk treatment plan to be put in place and monitored.

This should be done by applying assessment criteria. The assessment criteria should be as follows:

- Does risk identified put at risk one of the key strategic objectives identified in the Assurance Framework;
- Does the risk identified put into significant question a key control identified in the Assurance Framework;
- Does the risk identified bring into significant question any of the assurances identified in the Assurance Framework?

Risks with a rating of 'extreme' (15 or more) will be escalated to the Assurance Framework as a gap in control or assurance against the relevant strategic objective(s).

7.5   Risk Assessment Procedures

7.5.1 Identification of risks

This will be through the business planning process and in addition key committees and senior managers will identify any risk that requires an assessment for inclusion in the Risk Register or Assurance Framework. Managers and functional teams may wish to use other techniques to identify unusual or low intensity risks. This may include incident data analysis, use of brainstorming through team or management meetings, the use of learning events internally and externally, inspections, peer review of service delivery and practice, or benchmarking.

7.5.2 Assessment and analysis of risks

NHS Barnsley Clinical Commissioning Group will adopt a common framework for the assessment and analysis of all risks using the risk matrix (see appendix 2 and paragraph 7.5.3). The resulting ratings of each risk's consequence and likelihood is entered in the Risk Register. The actions required to treat the risks are recorded in the Risk Register, which is updated as risks continue to be assessed and treated. Separate action plans will be maintained in respect of extreme risks.

7.5.3 Risk Quantification

Each risk identified and recorded in the risk register will be quantified for its effect and potential risk to the organisation. Each of these elements will be scored on a scale of 1 to 5 by applying the matrix at Appendix 2, and the two scores multiplied together to give an overall risk rating out of 25.
The rating will be recorded in the risk register and reviewed and updated regularly by responsible senior managers and Committees.

7.5.4 Creation of Action Plans and Risk Controls

For each risk where there is a requirement to treat the risk, there will be an action plan relating to the risks contained in the register. The action plans will contain proposed mitigation and controls to be put in place to manage,

transfer or eliminate the risk identified. The existing controls will also be required to be monitored to assess their effectiveness within the plan.

It will be the responsibility of each senior manager to ensure that the risks and action plans for which they are responsible are regularly reviewed to keep them up to date. Risks are constantly changing and actions should be being progressively implemented.

7.5.5 Risk Controls and Mitigation

Effective key controls need to be in place if risks are to be effectively managed. The relationship between risks and controls is not straightforward. One specific risk may be mitigated by a number of controls. Some controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk. For each risk entered in the Risk Register the adequacy of the control(s) relating to the risk will be assessed and any necessary action determined and entered in the Action Plan.

7.5.6 Costs

Any additional costs of implementation will be identified in the annual financial plan and be subject to financial standing orders and financial risk mechanisms within the organisation

7.5.7 Risk elimination and transfer

There is recognition that all risks cannot be eliminated. Extreme risks on the Assurance Framework and Risk Register (scored 15 or more) should be treated until they reach a level that the Governing Body is prepared to tolerate (currently 12 or below). . High risks (8 to 12) will remain on the Risk Register and continue to be treated by the responsible senior manager and committee until such a time as they have been fully mitigated, at which point they will be removed from the Register.

7.5.8 Removal of Risks from Registers

Any risks removed from the register will be documented along with the decision making process and rationale. Committees are able to approve the removal of risks scored 12 or less, but Governing Body approval will be required to remove risks scored 15 or higher.

7.5.9 Definitions

The Assurance Framework and Risk Register columns include:

Area	Definition
Principal Risks	Those risks which affect the achievement of NHS Barnsley Clinical Commissioning Group objectives.
Uncontrolled risk	The initial risk score (consequence x likelihood) if there were no controls in place. This helps the organisation to

Area	Definition
	prioritise risks.
Current Risk	The residual risk score (consequence x likelihood) as at the present time with the listed controls in place.
Key Controls	The controls which are already in place to control the risk and reduce its likelihood of occurring. Controls can be preventative (stopping the risk occurring e.g. access controls), detective (If the risk is threatening to occur, how would you know? e.g. authorisation process) or directive (instructions or guidance in place to reduce the chance of the risk occurring e.g. policies).
Assurance	The assurances which are in place to check that the key controls for the risk are operating effectively e.g. reports, audits.
Positive Assurance	The positive assurances which have been received that confirm the risk is being effectively managed, and that key controls are in place and working e.g. positive Internal or External Audit Reports.
Gaps in Control and Assurance	The gaps identified in control or assurance, which, if addressed, would reduce the risk score.
Outcome	The risk treatment which is appropriate for the risk based on the risk description, the scoring and any gaps in either control or assurance. There are 4 categories to choose from: • **Treat** – Where there are insufficient controls and/or assurances in place, risks must be treated. Any risk scored with a risk rating of 12 or above should be treated. The risk treatment should be captured in an accompanying action plan. • **Tolerate** – Where the risk is deemed adequately controlled and there are sufficient assurances in place, risks can be tolerated providing that they are scored with a risk rating of 11 or below. • **Transfer** – Risks can be transferred to another organisation, therefore removing the associated risk e.g. transfer of commissioning decisions, transferring services or letting contracts with risk transfer clauses. • **Terminate** – It could be that the organisation wishes to avoid a particular risk altogether. This may involve ceasing the activity giving rise to the risk.

7.5.10 Training

This strategy identifies risk management as the business of everyone in NHS Barnsley CCG. The training and development of its staff is an integral part of the CCG's approach to risk management. Effective implementation of the strategy requires staff to be both aware of the NHS Barnsley CCG approach to risk management, and to be clear about their roles and responsibilities within the risk management process.

To this end, NHS Barnsley Clinical Commissioning Group has a programme of Mandatory and Statutory training which requires all employees to undertake regular training relevant to the management of key risk areas including:

- Data Security & Awareness
- Fire Safety, Health and Safety, and Moving and Handling
- Equality and Diversity
- Fraud, Bribery and Corruption
- Safeguarding Adults and Safeguarding Children

In addition, every member of staff will have an annual personal development interview with their line manager and agree a Personal Development Plan. This process provides assurance that the training needs of individuals are identified at all levels in the organisation, and serves to inform the content and delivery of future training programmes and plans.

All clinical and professional staff will operate within their code of professional conduct.

8 Monitoring the compliance and effectiveness of this strategy framework

The Head of Governance and Assurance will ensure that a process is in place to monitor the compliance and effectiveness of this strategy. This will include:

- Ensuring risks are considered at every meeting of every Committee of the Governing Body
- Providing Risk and Assurance exception reports to the Governing Body
- Taking the full Assurance Framework to the Governing Body three times a year and the full Risk register twice a year
- Taking the full Assurance Framework and Risk Register to Audit Committee twice a year, with exception reports to other meetings
- Supporting the Accountable Officer in reviewing the effectiveness of risk management arrangements through the annual Governance Statement.

9 Equality and Diversity

The Integrated Risk Management Framework will apply to all staff irrespective of their protected characteristics under the Equality Act 2010. The nine protected characteristics are age, disability, gender, gender reassignment, maternity and pregnancy, marriage and civil partnership, race, religion and belief and sexual orientation.

10 Strategy Framework Review

This strategy will be reviewed every three years. However the strategy may need earlier revision should there be a new requirement to meet statutory, mandatory or good practice standards.

Appendix 1

<h2 style="text-align:center">Index of Governance Criteria</h2>

Criterion 1 (Accountability)

There are clear accountability arrangements in place throughout the organisation.

Criterion 2 & 3 (Processes)

The Governing Body identifies the needs of its stakeholders on an ongoing basis and determines a set of key objectives and outcomes for meeting these needs, including how it meets its duty of quality.

The Governing Body ensures that there are proper processes in place to meet the organisation's objectives and secure delivery of outcomes.

Criterion 4 (Capability)

The organisation is capable of meeting its objectives and delivering appropriate outcomes.

Criterion 5 (Monitor, review, learn, improve)

The organisation learns and improves its performance through continuous monitoring and review of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

Criterion 6 (Independent assurance)

The Governing Body ensures that there are proper and independent assurances given on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

Criterion 7 (Outcomes)

The Governing Body can demonstrate that it has done its reasonable best to achieve its objectives and outcomes, including maintenance of a sound and effective system of internal control.

Risk Matrix

Table 1	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for > 7 days absence including weekend and bank holidays Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident over 7 day absence An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 1 Consequence scores (previous page)

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

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

(Table 2)

Table 3 Risk scoring = Consequence x Likelihood (C x L)

	Likelihood Score				
	1	2	3	4	5
Consequence ↓ Score	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1   Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2   Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3   Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4   Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score).

5   Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

The risk tolerance appetite under which risks can be tolerated is a score of 12 or below where the assessment has been undertaken following the implementation of controls and assurances.

Risk Register Template

Domains

1. Adverse publicity/ reputation

2. Business Objectives/ Projects

3. Finance including claims

4. Human Resources/ Organisational Development/ Staffing/ Competence

5. Impact on the safety of patients, staff or public (phys/psych)

6. Quality/ Complaints/ Audit

7. Service/Business Interruption/ Environmental Impact

8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description		Score
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	15 - 25
Likely	4	Major	4	Amber	High Risk	8 - 12
Possible	3	Moderate	3	Yellow	Moderate Risk	4 - 6
Unlikely	2	Minor	2	Green	Low Risk	1 - 3
Rare	1	Negligible	1	**Total = Likelihood x Consequence**		

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/ Treatment	Lead Owner of the Risk	Source of Risk	Residual Risk Score			Progress/ Update
			Likelihood	Consequence	Score				Likelihood	Consequence	Score	

Assurance Framework Template (Summary)   **Appendix 4**
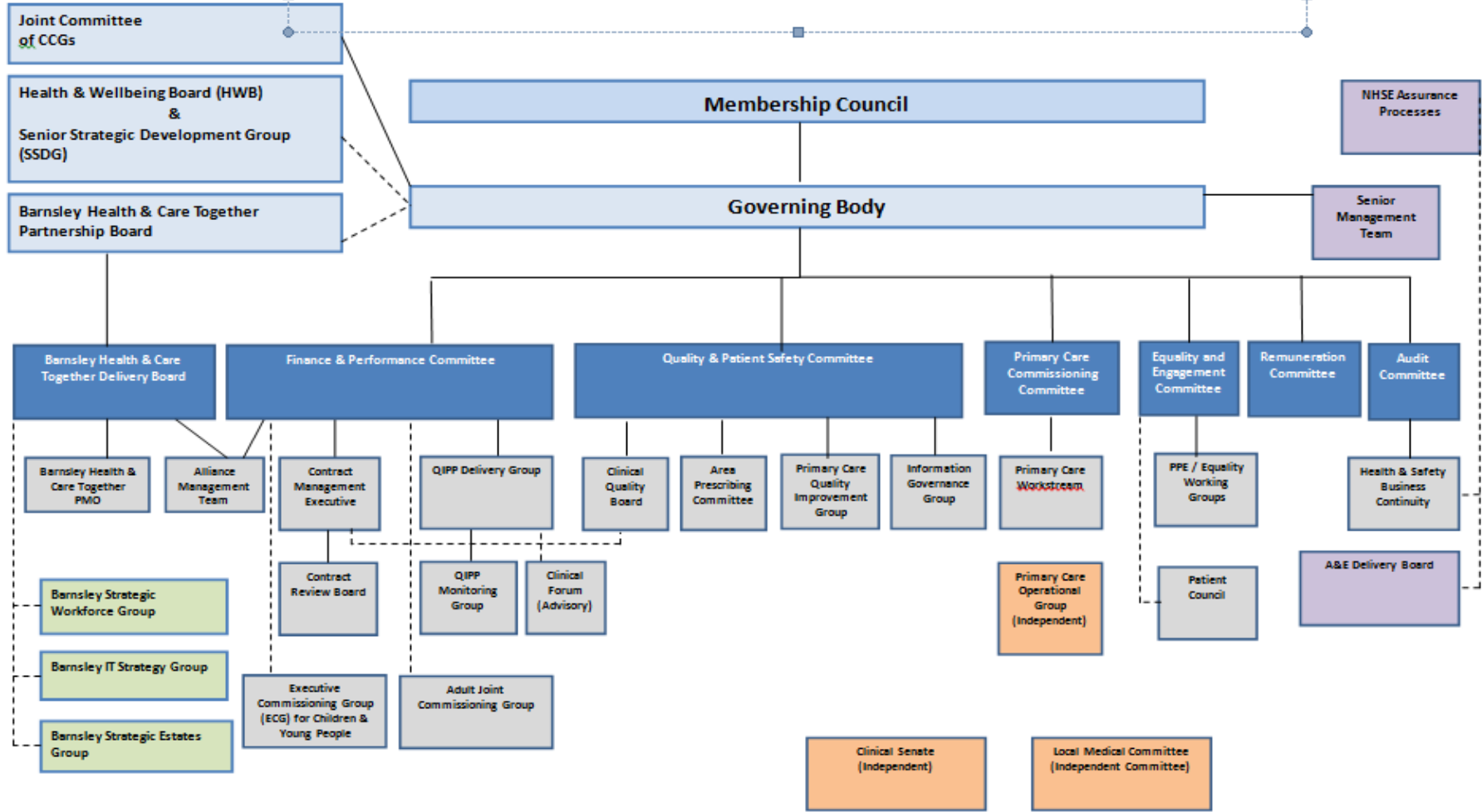
Introduction

The Governing Body Assurance Framework aims to identify the principal or strategic risks to the delivery of the CGG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and hence the key mitigating actions required to reduce the risks towards the target or appetite risk score. It also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG. The table below sets out the strategic objectives lists the principal risks that relate to them, and highlights where gaps in control or assurance have been identified. Further details can be found on the support pages for each of the Principal Risks.

Strategic Objective	Principal Risk(s)	Risk Owner	Initial score	Current score	Risk app'tite	Gaps in control	Gaps in ass'ce
					12		
					12		
					12		
					12		

| Date: | **NHS Barnsley CCG Governing Body Assurance Framework 2018-19** | | | | | | |

PRIORITY AREA X: (insert high level objective)	*Delivery supports these CCG objectives:*		**PRINCIPAL THREATS TO DELIVERY**
What would success look like?	Highest quality governance		Describe risk and associated adverse consequences
	High quality health care		
	Care closer to home		
	Safe & sustainable local services		
	Strong partnerships, effective use of £		
	Links to SYB STP MOU		

Committee Providing Assurance	**XX**	*Executive Lead*	**XX**	*Clinical Lead*		**XX**

Risk rating	Likelihood	Consequence	Total		Date reviewed		**xx/xx/xx**
Initial					Rationale:		
Current							
Appetite							
Approach	**TOLERATE**						

Chart: vertical axis 0, 10, 20; horizontal axis A M J J A S O N D J F M

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**

Gaps in assurance	**Positive assurances received**

Gaps in control	**Actions being taken to address gaps in control / assurance**

Committee Structure Barnsley CCG

Joint Committee of CCGs

Health & Wellbeing Board (HWB) & Senior Strategic Development Group (SSDG)

Barnsley Health & Care Together Partnership Board

Membership Council

NHSE Assurance Processes

Governing Body

Senior Management Team

Barnsley Health & Care Together Delivery Board

Finance & Performance Committee

Quality & Patient Safety Committee

Primary Care Commissioning Committee

Equality and Engagement Committee

Remuneration Committee

Audit Committee

Barnsley Health & Care Together PMO

Alliance Management Team

Contract Management Executive

QIPP Delivery Group

Clinical Quality Board

Area Prescribing Committee

Primary Care Quality Improvement Group

Information Governance Group

Primary Care Workstream

PPE / Equality Working Groups

Health & Safety Business Continuity

Barnsley Strategic Workforce Group

Contract Review Board

QIPP Monitoring Group

Clinical Forum (Advisory)

Primary Care Operational Group (Independent)

Patient Council

A&E Delivery Board

Barnsley IT Strategy Group

Barnsley Strategic Estates Group

Executive Commissioning Group (ECG) for Children & Young People

Adult Joint Commissioning Group

Clinical Senate (Independent)

Local Medical Committee (Independent Committee)

June 2018 CCG/Structures/Committee Structure Barnsley CCG

Equality Impact Assessment

Title of policy or service:	Risk Management Framework
Name and role of officer/s completing the assessment:	Kay Morgan, Governance and Assurance Manager
Date of assessment:	25 October 2016, Updated 23 August 2018
Type of EIA completed:	**Initial EIA 'Screening'** ☒ *or* **'Full' EIA process** ☐ *(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Including partners national or regional	The CCG's Risk Management Framework ensures that the Barnsley Clinical Commissioning Group meets its legal obligations for the management of all risks and to ensure consistency of approach • NHS Barnsley Clinical Commissioning Group Constitution • Standing Orders and Prime Financial Policies • Scheme of Delegation • Conflict of Interest Policy • Corporate Manual • Standards of Business Conduct Policy • Serious Incident Reporting Policy Procedure and Protocol • Policy for reporting all Incidents • Policy and procedure on raising concerns at work –"Whistle blowing" • Complaints Policy • Induction checklist • Health & Safety Policy

What outcomes do you want to achieve	
Give details of evidence, data or research used to inform the analysis or impact	A draft of this policy has been circulated for review by the following:- • BCCGs Information Governance Manager, • BCCG Governance and Assurance Manager, • BCCGs Equality and Diversity Lead, • Staff Side Union Representative, • Local Counter Fraud Officer The final policy has been signed off by BCCGs Chief Nurse and the Equality and Engagement Committee.
Give details of all consultation and engagement activities used to inform the analysis of impact	As above

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	New incident reporting form to be developed and launched to staff with training/guidance	Improved understanding of incident risk reporting
Age	☐	☒	☐		
Carers	☐	☒	☐		
Disability	☐	☒	☐		
Sex	☐	☒	☐		
Race	☐	☒	☐		
Religion or belief	☐	☒	☐		
Sexual orientation	☐	☒	☐		

Gender reassignment	☐	☒	☐		
Pregnancy and maternity	☐	☒	☐		
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐		
Other relevant groups	☐	N/A	☐		
HR Policies only: **Part or Fixed term staff**	☐	N/A	☐		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
New incident reporting form to be developed and launched to staff with training/guidance	Training guidance to staff	Numbers and quality of incident forms completed	By 30 December 2016	Head of Assurance Governance and Assurance Manager.

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	Head of Assurance	**Date of next Review:**	3 years in line with policy review date

Once completed, this form **must** be emailed to the Equality Lead for sign off:

Equality Lead signature: Date:	