NHS
Northumberland
Clinical Commissioning Group

Corporate	CO14: Risk Management Policy

Version Number	Date Issued	Review Date
V3.5	January 2022	01 July 2022 (or in line with Integrated Care Board establishment)

Prepared By:	Senior Governance Officer, North of England commissioning Support Unit
Consultation Process:	NHS Northumberland Clinical Commissioning Group, NECS Senior Governance Officer

Policy Adopted From:	CO14: Risk Management Policy (3.4)
Approval Given By:	Head of Planning and Operations

Document History

Version	Date	Significant Changes
1.0	01/04/2013	First Issue
2.0	12/09/2013	Updated following internal audit review and the implementation of the Safeguard Incident Risk Management System (SIRMS)
3.0	05/11/2014	Section 7.3 Best Practice Recommendations – NHS Audit Committee Handbook 2014. Reviewed and reformatted & SIRMS standard Operating Procedure included.
3.1	17/11/2017	Recommendation to extend policy. A full review is planned for March 2018. Updated Equality Impact Assessment and reference to General Data Protection regulation (GDPR).
3.2	18/06/2018	Updated Legislation and best practice with the latest updates
3.3	26/06/2019	New fraud, bribery and corruption wording included. Updated EIA assessment template included.
3.4	12/11/2021	Policy extended until 31/03/2022
3.5	20/01/2022	Policy extended in light of ICB establishment

Equality Impact Assessment

Date	Issues
June 2019	See Appendix B of this document

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Accessible Information Standards

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact norccg.enquiries@nhs.net

Contents

1. Introduction

This policy aims to set out the NHS Northumberland 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.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

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 will:

- Set out an organisation wide approach to managing risk, in a simple, straightforward and clear manner the intentions of the CCG for timely, efficient and cost-effective management of risk at all levels within the organisation.

The aims of the Policy are summarised as follows;

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

This policy applies to all employees and contractors of the CCG. Managers at every level have an objective to ensure that risk management is a fundamental part of the approach to integrated governance. All staff at every level of the organisation are required to recognise that risk management is their personal responsibility.

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

The following terms are used in this document:

- **Risk** is the chance that something will happen that will have an impact on the achievement of the CCG. 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).
- **Risk Appetite** the organisation's unique attitude towards risk taking that in turn dictates the amount of risk that it considers is acceptable.
- **Risk Management** is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
- **Risk Assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.
- **Residual Risk** the risk remaining after the risk response has been applied.

Examples of the types of risk that the CCG might encounter and need to mitigate against include;

- **Corporate risks** – operating within powers, fulfilling responsibilities, ensuring accountability to the public, governance issues.
- **Clinical risks** – associated with our commissioning responsibilities and including service standards, competencies, complications, equipment, medicines, staffing, patient information.
- **Reputational risks** – associated with quality of services, communication with public and staff, patient experience.
- **Financial** – associated with achievement of financial targets, commissioning decisions, statutory issues and delivery of the QIPP programme.
- **Environmental including health and safety** – ensuring the well-being of staff and visitors whilst using our premises.

3. Risk Management Framework

The CCG risk management framework sets out how risk management will be implemented throughout the organisation to support the realisation of the strategic objectives.

This includes the processes and procedures adopted by the CCG to identify, assess and appropriately manage risks and detailed roles and responsibilities for risk management.

3.1 Whenever risks to the achievement of the 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 CCG risk register has been developed with an aligned Standard Operating Procedure (SOP) risk register. The SOP has been developed based on current national guidance – see Appendix A Safeguard Incident Risk Management System (SIRMS) CCG Risk Register SOP. By all staff using the CCG risk register SOP it will ensure that risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will therefore allow for comparisons to be made between different risk types and for decisions to be made on the resources needed to mitigate the risk.

3.2 Risks are assessed in terms of the **likelihood** of occurrence/re-occurrence and the **consequences** of impact, using a standardised five by five risk assessment matrix (see Appendix A for full detail). For each risk that is not adequately controlled, an action plan to reduce or eliminate the risk is required. The implementation of the action plan and residual risk assessment must be kept under review, to assess whether planned actions have reduced or eliminated the risk as expected.

3.3 Once the category of risk has been identified, this then needs to be entered onto the appropriate CCG risk register. Please refer to section 3.7 below for further guidance on risk registers.

3.4 Any risk that is identified through the risk assessment process (as well as the incident reporting system) and 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

3.5. There are a number of ways in which risks can be managed, including

- **Avoiding the risk** by not undertaking the activity generating the risk
- **Eliminating the risk** where this is possible and cost effective through the use of control measures
- **Reducing the risk** to an acceptable level if it can't be eliminated
- **Transferring the risk** either fully or in part to another body – this may not always be possible where the organisation retains statutory responsibility. Examples of transferred risk would be insurance arrangements, e.g. the NHS Litigation Authority, where the payment of premiums means that in the event of a claim arising it is the NHSLA that bears the financial risk, or through contractual arrangements, partnerships or joint working where there is shared risk etc.
- **Monitoring the risk** but taking no action, particularly where it is a relatively low risk or cannot be eliminated, reduced or transferred.

3.6 Risk Appetite

3.6.1 The CCG endeavour 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 organisations 'risk appetite', this will ensure the CCG support a varied and diverse approach to commissioning, particularly for practices to work proactively to improve efficiency and value.

3.6.2 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 should not be confined to money. They will also invariably impact on the capability of the CCG, its performance and its reputation.

3.6.3 The Governing Body will set boundaries to guide staff on the limits of risk they are able accept to in the pursuit of achieving its organisational objectives. The Governing Body will set these limits annually and review them as appropriate.

3.6.4 The Governing Body will set these limits based on whether the risk is:

- A threat: the level of exposure which is considered acceptable
- An opportunity: what the Governing Body is prepared to put 'at risk' in order to encourage innovation in creating changes.

3.7 Corporate risk register

The CCG maintains a corporate risk register, which is a management tool used by the Governing Body to provide it with an overview of all significant 'live' risks facing the organisation and the action being taken to reduce them. The Corporate Risk Register is underpinned by local, committee risk registers, used by managers to monitor and manage risks at a departmental level within the organisation.

3.7.1 The risks included within the Corporate Risk Register are varied and cover the entirety of the CCG's activities, from health and safety risks to risks around the delivery of services and achieving financial balance. The Corporate Risk Register is therefore populated from a number of different sources, including:

- Principal risks identified in the assurance framework in relation to corporate objectives where action needs to be taken to close an identified gap in control measures;
- Risks identified by the Governing Body and via committee risk registers as being high or very high and requiring escalation to the audit committee;
- Any risks arising out of the Annual Operating Framework and the development of related action plans;

- Risks identified through evaluation of incident and complaints reporting;
- Risks identified through the evaluation of national 'incident' reports.

3.7.2 The corporate risk register is a live document, maintained on an on-going basis by the Head of Planning and Operations, and regular reports are provided to the Governing Body and relevant committees. The risk register is reviewed by the Audit Committee at least twice a year, or more frequently as required, with issues escalated to the governing body as appropriate.

3.7.3 Risks are considered monthly by the Governing Body, Quality Safety Group and the Medicines Optimisation Group as part of their standing agenda items. The Clinical Management Board reviews all risks bi-monthly and the updated corporate risk register is reviewed by the Audit Committee and Governing Body at least twice a year, or more frequently as required.

3.7.4 Each department is responsible for maintaining its own departmental risk registers, ensuring monthly updating and reports to relevant committee as outlined in the CCG constitution. Each committee risk register underpins the Corporate Risk Register and serves as a place to record local risks, including how they are being managed.

3.7.5 Risks within the departmental risk registers that have been assessed as being high or extreme are cascaded to the Governing Body monthly (or more frequently if it is required) for consideration around inclusion within the Corporate Risk Register.

3.7.6 The detailed committee structure that supports implementation of the risk management policy is set out in section 4.

3.8 Assurance framework/Strategic Risk Register

All government departments, including NHS organisations, are required to provide an annual assurance that they have robust systems in place across their organisation to manage risk. This assurance comes in the form of an *Annual Governance Statement*[1] [AGS] which must form part of the organisation's statutory accounts and annual report

3.8.1 In order to produce an AGS, the governing body must be able to demonstrate that they have been kept properly informed about the risks facing the organisation and has received assurances that these risks are being managed in practice, including that gaps in controls intended to manage risks have been identified and action taken to address them. The Governing Body will be able to demonstrate that it has met this requirement through the establishment of a robust and formal assurance framework.

[1] Formerly called the Statement on Internal Control

3.8.2 Together with this policy and the Corporate Risk Register, the Assurance Framework/Strategic Risk Register is the key document used by the Governing Body to monitor the position in relation to risk management, providing it with a sound understanding of not only the key risks facing the organisation but also the action being taken to manage and reduce them.

3.8.3 The Assurance framework/Strategic Risk Register is firmly connected to the organisation's principal objectives as set by the governing body, and is a live document, maintained on an on-going basis by the Head of Planning and Operations. Regular reports are provided to the Governing Body and relevant sub-committees. Within Northumberland CCG, the assurance framework/Strategic Risk Register is overseen by the Governing Body on behalf of the CCG, and should be reviewed by the Audit Committee at least twice a year.

3.8.4 The assurance framework/Strategic Risk Register sets out:

a. the organisation's principal objectives;
b. any significant risks that may threaten the achievement of those objectives;
c. the key controls intended to manage these risks;
d. the assurance available to demonstrate that controls are working effectively in practice to manage risks together with the source of that assurance.
e. any areas where there are gaps in controls and/or assurances; and
f. how the organisation plans to take corrective action where gaps have been identified in either controls or the assurances available.

4. Duties and Responsibilities

Clinical Commissioning Group (CCG)	The CCG consists of the membership of Northumberland CCG and will receive both twice yearly updates on risk management arrangements. The Risk Management structure for Northumberland CCG is set out below:
Governing Body	The CCG has delegated responsibility for risk assurance to its Governing Body. The Governing Body is responsible for reviewing the effectiveness of internal controls and is required to produce statements of assurance around the management of risks and demonstrating that it organises the affairs of the organisation efficiently and effectively. The Governing Body is supported in this by several committees and groups, including the Audit Committee, Clinical Management Board, Quality and Safety Group and the Medicines Optimisation Group. Governing Body: has overall responsibility for ensuring that robust systems are in place to manage risks and governance issues, including determining policy and reviewing the assurance. framework and corporate risk register at least twice a year.

Audit Committee	Audit Committee: provides independent oversight of the internal control arrangements in place within the organisation and has delegated responsibility from the governing body to ensure that: • the systems, policies and people in place are operating in a way that is effective, is focussed on key risks and is driving the objectives of the statutory organisation; • any activities within its terms of reference are investigated and to seek any information it may require from any employee; and • outside legal and other professional advice is obtained if it considers this necessary. The Audit Committee is chaired by an appropriately qualified Lay member and receives both regular updates in relation to the operation of controls and independent assurances such as those provided by internal and external audit. The Audit Committee members are independent of executive and line management.
Staff accountability	Risk management is the responsibility of all members of staff; however, there are roles within the organisation that have particular responsibility for certain elements of it. These are set out below:
Accountable Officer	The Accountable Officer has overall responsibility for: • ensuring the implementation of an effective risk management system; • developing a corporate governance framework; • meeting all statutory requirements; and • ensuring positive performance towards the achievement of strategic objectives across the CCG.
Chief Operating Officer (COO)	The COO is the executive lead director for risk management and governance. The COO is a member of the Governing Body
The Director of Nursing, Quality and Patient Safety	Director of Nursing, Quality and Patient Safety is the executive lead director for clinical governance and quality.

The Executive Director of Commissioning, Contracting and Corporate Governance	The Executive Director of Commissioning, Contracting and Corporate Governance leads on the implementation of corporate governance and risk assurance systems across the CCG and the management of risk associated with corporate governance, information requests and business continuity. The Executive Director of Commissioning, Contracting and Corporate Governance is a member of Governing Body. The Executive Director of Commissioning, Contracting and Corporate Governance is supported by the Corporate Affairs Manager and the Corporate Risk and Assurance Team at the Commissioning Support Organisation.
The Corporate Risk and Assurance team	The Corporate Risk and Assurance team at the Commissioning Support Organisation offers assistance on the implementation and co-ordination of the risk management process and the development and implementation of corporate risk assurance systems across the CCG, as well as assisting with the development and maintenance of the CCG assurance framework/Strategic Risk Register and corporate risk register. It also provides advice and training to managers on risk controls and their effectiveness.
Officers and Senior Managers	Officers and Senior Managers have corporate responsibility for risk management, and are responsible for taking a lead on risk management in their particular areas. Examples of this include the Chief Finance Officer taking a lead on finance risks including counter fraud and the implementation of the standing financial orders and instructions; Estates; and IM&T risks, while the Director of Nursing, Quality and Patient Safety leads on the management of risks associated with patient safety. The responsibilities of each senior manager in respect of risk management are set out in their job descriptions.

Managers	Managers are responsible for the management of risk and the implementation of the risk management policy within their particular areas. Their responsibilities include: • ensuring there are effective methods of identifying risk, including carrying out any necessary risk assessments • taking action to reduce risk wherever possible • ensuring that any remaining high risks, including those that cannot be dealt with locally, are communicated to the senior management team and ultimately the Governing Body if appropriate; • developing, maintaining, and reviewing departmental risk registers; • ensuring that all staff within their areas are made aware of the risks within their work environment and of their personal responsibilities, and that they receive appropriate information, instruction and training to enable them to work safely, which would include attendance at statutory and mandatory training; • ensuring all incidents are reported and investigated in line with procedures, and that any identified risks arising out of these investigations are included within department risk registers where appropriate.

All staff	All staff, including temporary, agency and consulting staff, have responsibilities for risk management and should: • be aware of and comply with trust policies and procedures in relation to risk management and understand the relevance to their area of work; • maintain safe working practices, including clinical practices, to safeguard themselves, their colleagues, patients and the wider public, and to discharge their duties under legislation • identify risks in relation to their working environment and role, and take appropriate action to assess them, take action and/or report them to their line manager; • report incidents, accidents and near misses using the CCG's incident reporting procedure; and • attend statutory and mandatory training programmes and any other training identified through personal development plans.
Senior Governance Manager (NECS)	NECS Senior Governance Manager will provide risk management support and advice.
AuditOne	Manages fraud on behalf of Northumberland CCG.

5. Partnership working

5.1 The CCG may establish partnership working relationships with other agencies, including but not limited to local authorities, the voluntary sector, Police Authorities, patient representatives and other CCGs.

5.2 In some cases, these arrangements will be intended to manage and reduce risk across the wider health and social care economy, for example arrangements around safeguarding. However, in other cases the existence of joint working arrangements may pose challenges that need to be managed to ensure that objectives can be delivered.

5.3 Where such partnership arrangements exist, the CCG will ensure that they work closely and collaboratively with partners to ensure that risk management is fully integrated into joint working arrangements and to identify any risks that need to be captured and reported within the CCG's internal processes.

6. Implementation

6.1 This policy will be available to all staff for use and be available through the intranet and public websites for the CCGs. It will also be available from the Governance lead and all line managers.

6.2 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.

6.3 The CCG has adopted a standardised framework for the assessment and analysis of all risks encountered in the organisation and which is set out in this policy. The implementation of this policy is achieved through the implementation and monitoring of the risk management framework outlined in section 3. It is also supported by a detailed reporting structure through its various committees and which are described in the policy. Directors and senior leads will be responsible for ensuring the policy is implemented in their areas of responsibility and compliance with this policy may be monitored through a process of auditing as set out by the Governing Body.

6.4 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.
- Approves and reviews strategies for risk management on an annual basis.
- Receives regular reports from the relevant committees and groups identifying significant clinical risks and mitigating actions.
- Receives regular reports from the relevant committees and groups on significant risks to delivering financial balance and the delivery of the Quality, Innovation, Productivity and Prevention programme.
- Demonstrates leadership, active involvement and support risk management.

This policy will be reviewed every three years by the Governing Body or sooner should legislative changes need to be made.

6.5 The CCG recognises the risk that fraud, bribery and corruption can pose to its resources. As a result, a risk has been included on the risk register to reflect this, with an appropriate risk owner and lead 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 through its fraud risk planning tool.

Regular meetings will be held between key CCG staff (i.e. Chief Finance Officer and Head of Corporate Affairs) and the AuditOne counter fraud specialist to review existing and any emerging risks. Regular reports will be provided to the Audit and Risk Committee as part of the risk register review process and counter fraud updates to ensure effective executive and lay member monitoring of fraud, bribery and corruption risks.

7. Training Implications

The sponsoring director will ensure that the necessary training or education needs and methods required to implement the policy and procedure(s) are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

The training required to comply with this policy is key to the successful implementation of this policy and embedding a culture of risk management in the organisation. Through a training and education programme staff will have the opportunity to develop more detailed knowledge and appreciation of the role of risk management. Training and education in risk management will be offered through regular staff induction programmes, annual mandatory training sessions and a rolling programme of risk management and training programmes.

8. Documentation

8.1 Other related policy documents

- Incident Reporting and Management Policy

8.2 Legislation and statutory requirements

This Risk Management policy is developed with reference to Department of Health publications and publications of expert bodies on governance and risk management:

- Data Protection Act 2018
- General Data Protection Regulations 2016
- Principles and framework contained in the legislation including: Health and Safety at Work Act 1974
- Principles contained within the Information Governance toolkit
- Risk Management Matrix for Risk Managers National Patient Safety Agency, (NPSA) (2008) ISO 31000 -2009

8.3 Best practice recommendations

- NHS Audit Committee Handbook (2014)
- Building the Assurance Framework: A practical Guide for NHS Boards March 2003. Gate log Reference1054
- Integrated Governance Handbook 2006
- Intelligent Commissioning Board (2006 & 2009)
- Making a Difference – Review of Controls Assurance Gateway Ref. No. 4222
- NHS Litigation Authority – CNST Risk Management Standards
- Governing the NHS: A guide for NHS Boards (2003)
- Taking it on Trust – Audit Commission (2009) Institute of Risk Management
- The Healthy NHS Board: Principles for Good Governance (2010)
- POL – 1015 Risk Management Strategy
- POL – 1000 Risk Management: Policy and Procedure
- POL – 1002 Health & Safety: Policy & Corporate Procedures
- POL – 1003 Incident management: Policy & Corporate Procedures
- POL – Business Continuity Policy: Policy & Corporate Procedures

9. Monitoring, Review and Archiving

9.1 Monitoring

The Clinical Management Board will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

9.2 Review

9.2.1 The Clinical Management Board will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

9.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Clinical Management Board will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

9.2.3 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.

9.3 Archiving

The Clinical Management Board 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 - Risk Register Operating Procedure

Risk Register
Operating Procedure

Appendix B – Equality Impact Assessment

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: Elizabeth Durham Role: Senior Governance Officer (NECS)

Title of the service/project or policy:

Northumberland CCG Risk Management Policy

Is this a:

x	Strategy / Policy		e 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 CCG's approach to risk and the management of risk in fulfilment of its overall objective to commission high quality and safe services

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

Consider the actual and potential impacts:

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

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:

This is an overarching policy which defines the risk framework (e.g. how to identify, assess and report risks). Separate policies exist which provide more detail how to manage specific types of risk and processes (e.g Health and Safety, Complaints, Safeguarding etc) and these will have more detailed consideration how to manage specific equality and diversity risks.

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**

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.

If you are not completing 'STEP 2 - Equality Impact Assessment' this screening document will need to be approved and published alongside your documentation.

A copy of all screening documentation should be sent to: **NECSU.Equality@nhs.net** for audit purposes.