Risk Management Strategy

February 2020

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Version Control

Version	Amendment	Author and Date
4.003	Section 13 and Equality Impact Assessment revised	Dawn Taylor, YHCS Corporate Services Manager, 15 December 2014
4.004	Strategy review	Gill Dixon, YHCS Risk and Assurance Lead Jan 2016 Michelle Longden, Hull CCG Corporate Affairs Officer Jan 2016
5	Strategy review	Michelle Longden, Hull CCG Corporate Affairs Officer – Feb 2017
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7	Strategy review	Michelle Longden, Hull CCG Corporate Affairs Manager – Mar 2019
8.2	Policy Review	Michelle Longden, Hull CCG Corporate Affairs Manager – March 2020

Contents

1. INTRODUCTION

All actions contain inherent risks. Risk Management is central to the effective running of any organisation. At its simplest risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. NHS Hull Clinical Commissioning Group (CCG) will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

2. AIM

The aim of this Risk Management Strategy is to ensure that the staff, patients, visitors, reputation and finances of the CCG are protected through the process of risk identification, assessment, control and elimination/reduction. This process also supports the effective delivery of the CCG objectives.

3. DEFINITIONS

Definitions of the terms used in this Risk Management Strategy are included in Appendix 1.

4. OBJECTIVES

The objective of the Risk Management Strategy is to create a framework to achieve a culture that encourages staff to:

- Avoid undue risk aversion but rather identify and control risks which may adversely affect the operational ability of the CCG.
- Compare and prioritise risks with one another using the risk grading guidance at Appendix 2.
- Where possible, eliminate or transfer risks or reduce them to an acceptable and cost effective level, otherwise ensure the organisation accepts the remaining risk.

5. SCOPE

This strategy is applicable to

- All staff working for, on behalf of or commissioned to deliver services for the CCG (this includes all directly employed staff, bank, agency and contracted staff all risks inherent in the business activities of the CCG.

6. STRATEGIC RISKS

Strategic risks which threaten the strategic objectives of the organisation are identified by the CCG. These strategic risks are recorded in detail in the Board Assurance Framework (BAF) and an up to date position is provided in the bi-monthly reports to the Integrated Audit and Governance Committee. The Board also receives updates of the BAF mid-year and at year end, together

with assurance from the Chair of the Committee through their Assurance Report.

7. RISK APPETITE

The term 'risk appetite' refers to the level of risk an organisation is willing to take in pursuit of its strategic objectives.

NHS Hull CCG's aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the likelihood and consequences of a risk occurring. NHS Hull CCG recognises that the risks are sometimes dictated to an organisation as well as the organisations identifying its own risks.

If the assessment of the risk is higher than the risk appetite, further action should be taken to reduce the likelihood and/or impact of the risk occurring. If this is not possible, contingency plans should be put in place to bring the risk exposure level (residual risk) back within the accepted range.

NHS Hull CCG recognises that some risks or hazards should never be incurred, whilst in other cases it is a matter of ensuring that the counter-measures taken to reduce the identified risks are proportionate, i.e. there is a conscious decision taken regarding what is an acceptable level of risk so that those who are responsible for managing the risk, willingly consent to the possibility of foreseeable, adverse consequences and have agreed appropriate risk mitigation plans in place to reduce the impact.

The CCG recognise the risks that fraud, bribery and corruption pose to its resources and have included this risk in the corporate (strategic) risk register. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by the CCG's counter fraud provider, AuditOne, as agreed in the counter fraud workplan and using their fraud risk planning tool. Regular meetings will be held between key CCG staff (i.e. Chief Finance Officer, risk staff) and the AuditOne counter fraud specialist to review existing and emerging risks and to ensure effective executive level monitoring.

8. STAFF

All members of staff have an important role to play in identifying, assessing and managing risk; guidance on the risk process is at Appendix 3. To support staff in this the CCG provides a fair, consistent environment and encourages a culture of openness and willingness to admit mistakes. Staff are encouraged to report any situation where things have, or could have, gone wrong. Where necessary the CCG will provide information, counselling and support, and training for staff in response to any such situation. The CCG needs to learn from any such situation in order to continuously improve the risk management process.

In the interest of openness and the process of learning from mistakes, thorough consideration will be given in relation to the circumstances of any risk

management investigation before any formal disciplinary procedures commence.

However, a serious breach of health and safety regulations or serious negligence causing loss or injury are examples of gross misconduct and will be dealt with through the CCG's disciplinary procedure. Disciplinary action may therefore, be appropriate where it is found that a member of staff has acted:

- Illegally – against the law
- Maliciously – intending to cause harm which she/he knew was likely to be the result
- Reckless – deliberately taking an unjustifiable risk where she/he knew of the risk and chose to ignore it

If it is felt that disciplinary action is necessary this will be made clear as soon as the possibility emerges. Any investigation would then take into account the CCG's human resources policies and advice will be sought from human resources as appropriate.

9. ACCOUNTABILITY, RESPONSIBILITY AND ORGANISATIONAL FRAMEWORK

The Chief Officer has overall accountability for responsibility for risk management. A list of operational responsibilities for risk management is included at Appendix 4.

Board Assurance Framework (BAF)
NHS Hull CCG is supported in the assurance and governance process by the Board Assurance Framework. Through the BAF NHS Hull CCG gains assurance from responsible leads that risks are being appropriately managed in the organisation. The BAF is based on NHS Hull CCG's strategic objectives and principal risks.

Risk Registers
NHS Hull CCG has a corporate risk register which captures the corporate risks, this enables them to be analysed against the organisational objectives to ensure action is being taken to mitigate the risk.

Each Committee has their own risk register which feeds into the corporate risk register. Committees will review the adequacy of the description, mitigation and management action of relevant risks, The risk registers are reviewed and updated on a regular basis by responsible risk owners.

The Integrated Audit and Governance Committee will advise the CCG Board on the adequacy of the assurances available with respect to the Strategic Risk Register and Board Assurance Framework. This also includes the final approval of the removal of a high or extreme risk from the Strategic Risk Register or Board Assurance Framework and the regularly review, confirm and challenge of the documents contents.

Information Risk Management

Information risk is inherent in all administrative and business activities and everyone working for or on behalf of the CCG continuously manages information risk. The Governing Body recognises that the aim of information risk management is not to eliminate risk, but rather to provide the structural means to identify prioritise and manage the risks involved in all Trust activities. It requires a balance between the cost of managing and treating information risks with the anticipated benefits that will be derived. The Governing Body acknowledges that information risk management is an essential element of broader information governance and is an integral part of good management practice. The intent is to embed information risk management in a very practical way into business processes and functions. This is achieved through key approval and review processes / controls – and not to impose risk management as an extra requirement. The objectives of information risk management are:-

- Protect the CCG, its staff and its patients from information risks where the likelihood of occurrence and the consequences are significant;
- Provide a consistent risk management framework in which information risks will be identified, considered and addressed in key approval, review and control processes;
- Encourage pro-active rather than re-active risk management;
- Provide assistance to and improve the quality of decision making throughout the CCG;
- Meet legal or statutory requirements; and
- Assist in safeguarding the CCG's information assets.

The Senior Information Risk Owner (SIRO) is responsible for coordinating the development and maintenance of information risk management policies, procedures and standards for the CCG.

The SIRO is responsible for the ongoing development and day-to-day management of the CCG's Risk Management Programme for information privacy and security.

CCG Information Asset Owners (IAOs) shall ensure that information risk assessments are performed at least bi-annually on all information assets where they have been assigned 'ownership'. Assessments are completed as part of the Information Asset Register. Further guidance on the completion of information risk assessments can be found in the IAO Role and Responsibilities guidance document.

Risk assessments will be summarised as part of the IAR reports to the SIRO and mitigating plans. Mitigation plans shall include specific actions with expected completion dates, as well as an account of residual risks.

10. MONITORING THE STRATEGY

A risk report is presented to every meeting of the Integrated Audit and Governance Committee. This report highlights the progress against all high and medium risks, lists any new high or extreme risks identified and any of these risks which have been requested to be closed.

11. IMPLEMENTATION

The effective implementation of this strategy along with staff training will provide awareness of the need to prevent, control and contain risk.

12. TRAINING

This strategy will be published on the website to ensure it is available to all staff and stakeholders.

Risk management training will be provided as and when required.

New risk owners are provided with a guide and 1.1 training is provided as required.

13. EQUALITY IMPACT ANALYSIS

This is a strategy fundamental to how the CCG operates but is an internal management-focused document and so does not impact directly on the public. It will not have a differential impact on any equality group.

This strategy could help identify risks within the organisation which impact on equality and diversity.

As a result of performing the analysis the strategy does not appear to have any adverse effects on people who share Protected Characteristics. The full Equality Impact Analysis and action plan is available at Appendix 5.

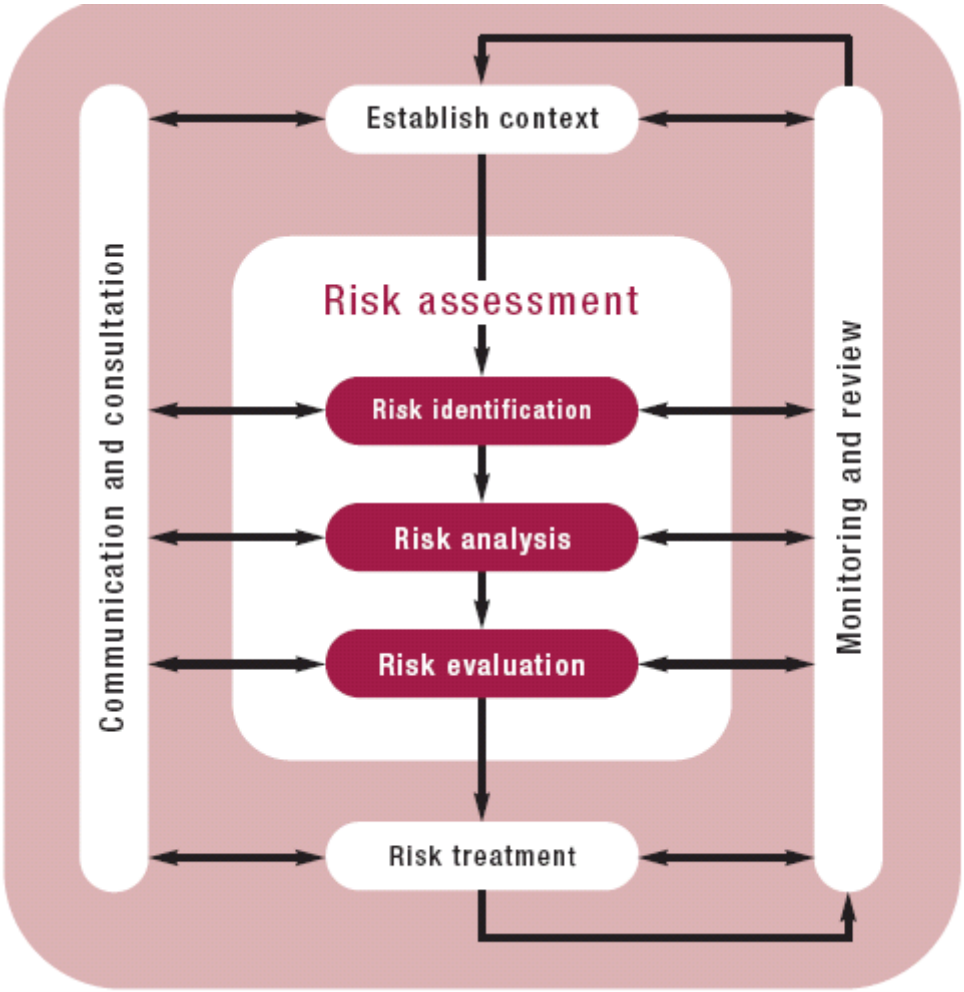
APPENDIX 1

Definitions

Risk is the chance that something will happen that will have an impact on the achievement of NHS Hull CCG'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).

Risk Management is 'the culture, process and structures that are directed towards the effective management of potential opportunities and adverse effects'.

The risk management process is 'the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communication risk'. See diagram below and Appendix 3 which provides detail on the risk management process.



Risk Management Overview from ISO31000

Significant risks are those which when measured using the risk matrix at Appendix 2 are assessed to be high or extreme or threaten a corporate objective. NHS Hull

CCG's Integrated Audit and Governance Committee and Board will take an active interest in the management of significant risks.

APPENDIX 2

Risk Scoring Matrix Methodology

Table 1 Consequence score ©

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.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Patient and staff safety	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days. RIDDOR reportable incident 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 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	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint 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 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	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	Short-term low staffing level that temporarily reduces	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack	Non-delivery of key objective/service due to lack

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Development	service quality (< 1 day)		Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	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	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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Extreme**
Finance	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 **Impact on environment**	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 Extreme impact on environment

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
Probability Percentage likelihood of occurrence	0-5%	6-20%	21-50%	51-80%	81-100%

Table 3 Risk scoring = consequence x likelihood (C x L)

Calculate the risk score by multiplying the consequence score by the likelihood score:

Likelihood of occurrence	Consequences/Severity				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Table 4 – Risk Management

A risk score is calculated to enable the organisation to prioritise the management of the risk against the organisation in terms of timescale and management responsibilities. Risks are then ranked into one of four categories shown in the table below:

	LOW RISK (1-3)	**MODERATE RISK (4-6)**	**HIGH RISK (8-12)**	**EXTREME RISK (15-25)**
Timescale	Minimal action may be required.	Action/s within 6-8 months.	Action/s within 3–6 months.	Immediate action to remove/reduce risks. Action to be taken on recommendations/ further controls within 8 weeks. Action/treatment plan required.
Management Requirements	Manage/monitor situation within team.	Usually handled within the team by line manager.	Senior Managers to lead on management	Director to lead on the management. Escalate to Integrated Audit and Governance Committee

Red (extreme) risks should have a formal review and be escalated to the Integrated Audit and Governance Committee to ensure robust controls and mitigating action has been identified and to monitor actions taken to reduce the risk to an acceptable level.

APPENDIX 3

RISK MANAGEMENT PROCESS

1. INTRODUCTION

Risk Management covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them and monitoring and reviewing progress.

In order for the CCG to manage and control the risks it faces, it needs to identify and assess them. This appendix provides a guide to assist staff to undertake risk management systematically and will ensure consistency of approach across the organisation.

2. IDENTIFICATION OF RISK

Risk identification involves examining all sources of risk, from the perspective of all stakeholders, both internal and external. Within the CCG, risks are identified using a number of sources.

Internal Methods of Identification

- Adverse Incidents, Serious Incidents (SIs), complaints, patient relations enquiries and claims reporting.
- Internal audit recommendations, identifying the CCG's gaps in control.
- Self assessment workshops.
- Strategic level risks highlighted by CCG Governing Body, and Directors.
- Risks highlighted via committees of the Governing Body.
- Patient satisfaction surveys.
- Staff surveys.
- Risks highlighted by new activities and projects.
- Risks highlighted via the Whisteblowing (Raising Concerns) Policy.
- Risks highlighted through business and local development plans.

External Methods of Identification

- Reports from assessments/inspections from external bodies ie CCG external auditors, Care Quality Commission, NHSLA Risk Management Assessors, Health and Safety Executive (HSE) etc.
- National reports and guidance.
- Coroner's reports.
- Media and public perception.
- National Patient Safety Agency (NPSA) alerts.
- Central Alerting System (CAS) alerts.
- Parliamentary and Health Service Ombudsman reports.

3. RISK ANALYSIS

Following identification, risks will be both categorised and prioritised using a risk assessment that includes a grading system which assesses the level of risk based upon

measurement of the likelihood of the risk occurring and the consequence of the occurrence (likelihood x consequence) using the risk matrix guidance at Appendix 2. Risks will be analysed to determine their cause, their impact on the business of NHS Hull CCG if they are not dealt with, the likelihood of them occurring or recurring and how they may be managed. The outcome of this analysis will be documented on a register of risks.

4. RISK EVALUATION

This is the process used to determine risk management priorities by comparing the level of risk against agreed target risk levels or other criteria. Standardised systems will continue to be established to ensure that risk assessments are undertaken in a consistent format using agreed definitions and evaluation criteria allowing all risks to be graded in the same consistent manner. This allows for meaningful comparisons to be made between different types of risk and for judgments and decisions about resource allocation to be made on that basis.

5. RISK TREATMENT

Risk treatment is the activity of selecting and implementing appropriate control measures to modify and/or manage the risk. NHS Hull CCG will aim to reduce risks to the lowest level reasonably practicable.

All risks can be either:

- Avoided
- Transferred
- or retained

CCG Managers will use all facts available to determine which of these options is the most appropriate and will make a balanced judgment on how a risk will be managed. Ideally risks will be avoided either by the adoption of alternative practices or different approaches.

Actions already undertaken to address the identified risks (existing controls) will also be graded using the model to indicate the residual risk rating, i.e. how much risk the CCG is exposed to.

6. MONITORING AND REVIEW

Information from the assessment of risks will be used to populate the NHS Hull CCG Risk Register, enabling risks to be quantified, ranked and costed. The register will identify constraints to progressing actions that would reduce the identified risks. This will provide one of the main sources of information regarding risks in the CCG and be an aid to directing finite resources to areas of greatest risk.

7. COMMUNICATION AND CONSULTATION

It is important that the reputation of NHS Hull CCG is protected through the process of risk identification, assessment, control and elimination.

NHS Hull CCG identifies with the concerns of the wider public and will utilise the risk management processes to capture intelligence regarding the safety of services from the patient and public perspective. We will actively involve patients and the wider community

in the development of the risk management processes through enabling patients and the public to provide feedback on their experiences through a variety of ways including:

- Patient and public engagement events;
- Representatives on our Committee's;
- Seeking patient and public views during consultations;
- Provider information in relation to complaints/comments/concerns and compliments, and
- Provider information in relation to adverse incidents and serious incidents.

Systems of communication with external stakeholders that contribute to minimising risk are in place, including, regular stakeholder engagement meetings, publications, the annual general meeting. This Risk Management Strategy is available to all staff and other stakeholders via the website.

For further information on how to undertake a risk assessment, please contact the Health and Safety Lead.

APPENDIX 4

RESPONSIBILITY FOR RISK MANAGEMENT

1. Chief Officer

NHS Hull CCG's Chief Officer has overall responsibility for risk management. Through delegated responsibility the Chief Officer will have day to day management of the organisations risk management process.

2. Chief Finance Officer

The Chief Finance Officer will have responsibility for financial risks and ensure these are appropriately managed.

3. Integrated Audit and Governance Committee

The Integrated Audit and Governance Committee will regularly review and advise the CCG Board on the adequacy of the assurances available with respect to the Strategic Risk Register and Board Assurance Framework. This also includes the final approval of the removal of a risk from the Strategic Risk Register or Board Assurance Framework and the regularly review, confirm and challenge of the documents contents.

4. Senior Leadership Team

The Assurance Framework and Risk Register are also presented to the Senior Leadership Team for monitoring and review.

5. Associate Director of Corporate Affairs

Is the delegated Director for risk management and these responsibilities include ensuring that the CCG develops and maintains an effective Board Assurance Framework and Risk Registers.

6. Corporate Affairs Manager

The Corporate Affairs Manager will support the Associate Director of Corporate Affairs to facilitate the risk management process within the CCG.

7. Responsible Leads/Directors

Responsible leads will ensure that risks are highlighted and entered onto the risk register and updated, reviewed and managed appropriate.

APPENDIX 5

HR / Corporate Policy Equality Impact Analysis:	
Policy / Project / Function:	Risk Management Strategy
Date of Analysis:	03 February 2020
Completed by: **(Name and Department)**	Michelle Longden, Corporate Affairs Manager
What are the aims and intended effects of this policy, project or function?	To set out the CCG's strategy in relation to risk and risk management
Are there any significant changes to previous policy likely to have an impact on staff / other stakeholder groups?	n/a
Please list any other policies that are related to or referred to as part of this analysis	Whistleblowing Policy Equality and Diversity Policy
Who will the policy, project or function affect?	All staff working for, on behalf of or commissioned to deliver services for the CCG (this includes all directly employed staff, bank, agency and contracted staff all risks inherent in the business activities of the CCG.
What engagement / consultation has been done, or is planned for this policy and the equality impact assessment?	Relevant employees and SLT Members have been involved in the development of this policy.

Promoting Inclusivity and Hull CCG's Equality Objectives. How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation? How does the policy promote our equality objectives: 1. Ensure patients and public have improved access to information and minimise communications barriers 2. To ensure and provide evidence that equality is consciously considered in all commissioning activities and ownership of this is part of everyone's day-to-day job 3. Recruit and maintain a well-supported, skilled workforce, which is representative of the population we serve 4. Ensure the that NHS Hull Clinical Commissioning Group is welcoming and inclusive to people from all backgrounds and with a range of access needs 5. To demonstrate leadership on equality and inclusion and be an active champion of equalities in partnership programmes or arrangements	Application of this policy helps ensure that the staff, patients, visitors, reputation and finances of the CCG are protected through the process of risk identification, assessment, control and elimination/reduction.

Equality Data	
Is any Equality Data available relating to the use or implementation of this policy, project or function? Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.*	Yes ✓ No Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document). If you answered No, what information will you use to assess impact? **Please note that due to the small number of**

Examples of *Equality Data* include: (this list is not definitive) 1: Recruitment data, e.g. applications compared to the population profile, application success rates 2: Complaints by groups who share / represent protected characteristics 4: Grievances or decisions upheld and dismissed by protected characteristic group 5: Insight gained through engagement	**staff employed by the CCG, data with returns small enough to identity individuals cannot be published. However, the data should still be analysed as part of the EIA process, and where it is possible to identify trends or issues, these should be recorded in the EIA.**

Assessing Impact

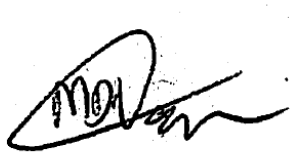
Is this policy (or the implementation of this policy) likely to have a particular impact on any of the protected characteristic groups?
(Based on analysis of the data / insights gathered through engagement, or your knowledge of the substance of this policy)

Protected Characteristic:	Neutral Impact:	Positive Impact:	Negative Impact:	Evidence of impact and, if applicable, justification where a *Genuine Determining Reason*[1] exists (see footnote below – seek further advice in this case)
Gender	x			This strategy applies regardless of Gender.
Age	x			This strategy applies regardless of Gender.
Race / ethnicity / nationality	x			This strategy applies regardless of Gender.
Disability	x			This policy applies to all regardless of disability.
Religion or Belief	x			This strategy applies regardless of Gender.
Sexual Orientation	x			This strategy applies regardless of Sexual Orientation.
Pregnancy and Maternity	x			This strategy applies regardless of Pregnancy and

1. [1] *The action is proportionate to the legitimate aims of the organisation (please seek further advice)*

				Maternity.
Transgender / Gender reassignment	x			This strategy applies regardless of Gender reassignment.
Marriage or civil partnership	x			This strategy applies regardless of Marriage of Civil Partnership.

Action Planning:				
As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse impact or strengthen the promotion of equality?				
Identified Risk:	**Recommended Actions:**	**Responsible Lead:**	**Completion Date:**	**Review Date:**

Sign-off
All policy EIAs must be signed off by Mike Napier, Associate Director of Corporate Affairs
I agree with this assessment / action plan
If *disagree*, state action/s required, reasons and details of who is to carry them out with timescales:
 **Signed:**
Date: 19.02.20