Trust-wide Document

NHS
Great Western Hospitals
NHS Foundation Trust

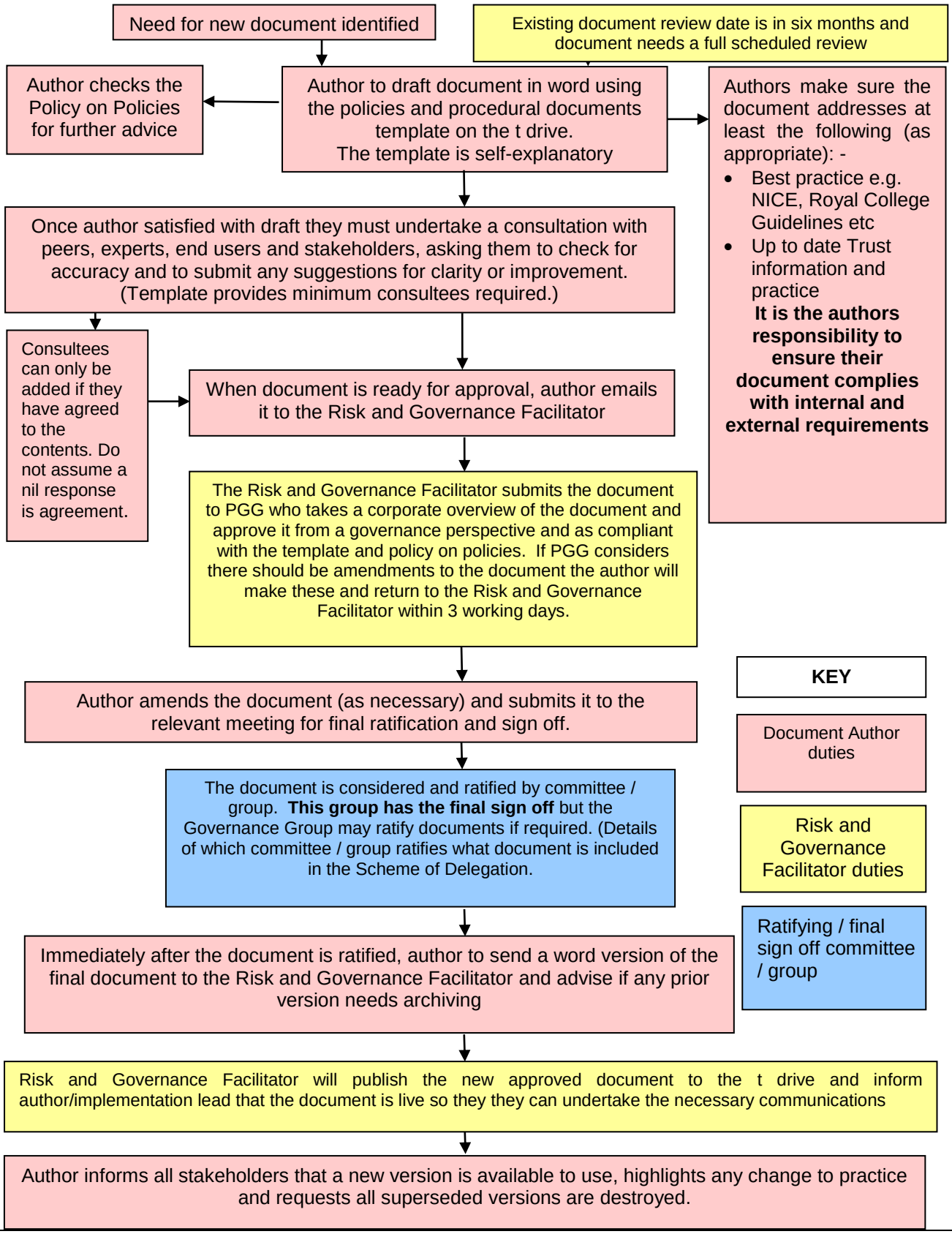
Development and Management of Policies, Guidelines (Clinical and Non Clinical) and Procedural Documents Policy

Document No	Corp - 00020	**Version No**	1.0
Approved by	Policy Governance Group	**Date Approved**	22.08.18
Ratified by	Trust Board	**Date Ratified**	06.09.18
Date implemented (made live for use)	10.09.18	**Next Review Date**	06.09.21
Status	LIVE		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract) involved in the creation of and/or review of policies and Trust wide procedural documents. It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
Special Cases	This policy sets out the process for documents within the Corporate Governance Review Programme. This policy does not apply to patient group directions, some clinical guidelines, standard operating procedures and low-level and short lifecycle documents. In some exceptional cases the work involved to follow this standard format may outweigh any benefits gained from standardisation and therefore the requirements of this policy will not apply. However, should authors of these documents wish to follow this policy they may do so.		
Accountable Director	Director of Governance and Assurance (DoG&A)		
Author/originator – Any Comments on this document should be addressed to the author	Risk and Governance Facilitator (R&GF)		
Division and Department	Corporate. Corporate Governance		
Implementation Lead	Risk and Governance Facilitator (R&GF)		
If developed in partnership with another agency ratification details of the relevant agency	N/A		
Regulatory Position	The Quality Care Commission (CQC) is the independent regulators of health and social care in England and regulates the Trust.		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Document Title: Development and Management of Policies, Guidelines (Clinical and Non Clinical) and Procedural Documents Policy

Contents

Instant Information – Document Review Process Flow Chart



1 Introduction & Purpose

The purpose of this document is to set out a framework for writing Great Western Hospitals NHS Foundation Trust (the Trust) policies, guidelines (clinical and non-clinical,) procedural and competency documents and to set out a Trust wide process for their production, review and approval/ratification.

The reasons for this are:-

- To enable the Trust to meet legal and other compliance standards.
- To provide a clear process for approving and ratifying policies, guidelines (clinical and non-clinical,) and procedural documents.
- Provides a robust policy management and approval system.
- To ensure a process for review and updating of Policies, Guidelines and Procedures.
- To ensure consistency in the delivery of practices and procedures within the Trust.
- To ensure policies and procedures are available for all employees within a recognised format.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

Approval	The document is checked, reviewed and approved as compliant with this policy and fit for purpose. Approval is only provided at Policy Governance Group
Clinical	Anything relating to patient care (such as medical care and procedures, patient treatment, surgery).
Consultation	A process which ensures all stakeholders are involved in and have the opportunity to comment on policies, guidelines (clinical and non-clinical,) and procedural documents developments so as to ensure they are fit for purpose.
CQC	Care Quality Commission
DoG&A	Director of Governance and Assurance
EIA	Equality Impact Assessment.
Guideline	Often confused with procedure, guidelines are a suggested course of action that provides advice as to when and how an activity should be performed.
NICE	National Institute for Health and Care Excellence
Non-Clinical	Anything relating to non-patient care
PGG	Policy Governance Group
Policy	A policy is a way of ensuring that the philosophy and goals of the service are applied uniformly throughout the organisation, forming a framework within which everyone works. Essentially it provides the organisation with rules.
Procedures	The term procedure implies that it is an established local sequence and uniform method for performing activity; it gives specific information for those performing the activity.
Protocol	A protocol is a series of procedures that identifies the boundaries of action for a single complete process.
R&GF	Risk and Governance Facilitator
Ratify	To sign or give formal consent to (a treaty, contract, or agreement), making it officially valid.

	In the case of the Trust to ratify is to have a document on the agenda of a group or committee in line with the Scheme of Delegation and the Group/Committee sign off the document and agree it is fit for purpose and can be made available to be implemented. The decision to ratify must be recorded on the minutes of the Group/Committee and provided to the R&GF as evidence of ratification. The Scheduled Full Review of a document is set at three years after the date the document was ratified.
Scheme of Delegation	The Reservation of Powers to the Board sets out those duties and responsibilities which will only be exercised by the Board. The Scheme of Delegation sets out the powers and duties to others, appended to which are the operational limits for exercising those delegated functions. The Board does not wish to ratify all the documents in the Trust so they delegate certain subject matters to other groups/committees to ratify and these are set out of the Scheme of Delegation
Stakeholder/Consultee	Is a party that has an interest in and can either affect or be affected by the business. In the context of this document a stakeholder is an: • Expert on the subject content, • Peer, • Provider of service such as Infection Prevention and Control, • Provider of portering, food services, linen etc, • End user – i.e. if the document is human resources document, most employees will be an end user whether as a manager or an employee going through the processes set out in the document. End users should be asked to read it to see if they can clearly follow the document, and that any questions they may have are answered within the document.
Strategy	An overall plan to achieve longer-term objective
T drive	Working drive that documents are saved onto - T:\Trust-wide Documents
the template	Refers to the template to be used for all policies, procedures, guidelines both clinical and non-clinical that are part of the Corporate Governance Review Programme and are stored on the t drive folder T:\Trust-wide Documents The template is only permitted to be used if the document is approved by PGG and ratified by a Group/Committee in line with the SoD and is part of the Corporate Governance Review Program

2 Main Document Requirements

This section provides details of the principles to be used in the development and management of policies.

All proposed policies, guidelines and procedures must be registered with the Risk & Governance Facilitator for inclusion on the central register of documents and allocation of a unique policy reference number (if required), this feeds the Corporate Governance Review Programme.

2.1 Meeting National Criteria

Authors must ensure that the document complies with all relevant and current legislative requirements relevant to that policy, both internally and externally.

Documents must be evidence-based and referenced accurately and must not contain details or references that do not exist. Where databases and web pages are cited as references, the data or contents should be the most recent available. Hyperlinks can be included within a policy, the organisation's chief web page should be provided only, such as www.nice.org.uk.

2.2 Style and Format

All policies, guidelines and procedures should be written using the standard template (see Appendix B) which sets out the font and type size as well as the standard headings. The only exception to amending the type size is for a table or flow chart that would otherwise be spread over two pages when implementing Arial size 10 would keep the information on one page.

The key features of a well-written document are that it:

- Is clear, concise, in straightforward language and written with all but the most obvious acronyms and specialised language explained when first used in the document.
- Takes account of the relevant views of stakeholders where appropriate;
- Has clear objectives;
- Clearly states to whom the document applies;
- Specifies how the document will be monitored and audited.

2.3 Content

It is evident that each policy, guideline or procedure will contain information specific to the subject area however, the basic content requirements are as follows:

- Instant Information (if applicable)
- Introduction and Purpose of the Document
- Main Document Requirements
- Monitoring Compliance and Effectiveness of Implementation
- Duties and Responsibilities of Individuals and Groups
- References, Further Reading and Links to Other Policies
- Equality Impact Assessment

2.4 Integrating Documents

There are periods of time when the Trust might undertake new services or patient cohorts that had previously been provided elsewhere and there may be occasions when the existing Trust documents will need to make provisions for these circumstances and ensure the documents are fit for purpose. This is to take place as soon as possible so that no one is at risk from out of date or multiple versions of the same document being live for use. The Author/Implementation Lead of the Trust document must lead on this integration.

2.5 Documents for Different Sites

Where there is a general policy, guideline (clinical and non-clinical,) and procedural document but slightly different arrangements applying to different sites, this information should be included in the Target Audience and the document title on the front page of the template. Site specific appendices with general guidance and information should be included in the main document content. Where it is

necessary to have a site specific document only, the title of the document must include the name of the site.

2.6 Consultation

It is the responsibility of the Author/Implementation Lead to agree and undertake the appropriate consultation with relevant stakeholders on the policy, guideline or procedure, prior to presenting the document for approval. Any groups/individuals consulted during the development or review of the policy, guideline or procedure should be listed at the front of the document

It is good practice to give consultation periods of at least one month to ensure that staff on leave and/or staff prioritising workloads are able to give the document appropriate attention.

3 Process for Full Scheduled Review

All policies, procedures and guidelines (both clinical and non-clinical) must include a review date which will be no longer than three years from ratification. The Risk and Governance Facilitator will maintain a policy, guideline or procedure tracker which will include:

- Document name and number.
- Review date.
- Record of approval body.

The policy, guideline or procedure review process starts six months prior to expiry date and Executive Leads will be notified of the list of documents and pending review date for action. It is the responsibility of the Executive Lead to identify an Author/Implementation Lead and to ensure that policies, guidelines (clinical and non-clinical) and procedural documents are integrated where applicable.

4 Process for Approval / Ratification

Once the policy, guideline or procedure has been produced and the necessary consultation process been undertaken the author/lead submits it to the Risk and Governance Facilitator for consideration at the Policy Governance Group. The author/lead will be invited to the meeting and will be responsible for any recommended amendments.

If further ratification is required it is the responsibility of the Author/Implementation Lead to submit to the relevant committee, group or meeting as specified in the Scheme of Delegation, which can be found on the t-drive.

5 Process for Changes to a Policy 'Outside Full Schedule Review'

5.1 Minor Change

If a minor change to a policy is required, approval by committee is not required. Minor changes are ones that do not affect working practice, or simply reflects existing practice. Examples of amendments would be:-

- Spelling corrections.
- Update of job titles.
- Update to links/reference to other documents
- Additional text to provide clarity which does not affect the overall process and intention of the document.
- Learning from incident or complaint.

Any amendments are to be made by the Author/Implementation Lead via tracked changes and emailed to the Risk and Governance Facilitator who will request the Director of Governance & Assurance to approve the tracked changes. Upon approval the Risk and Governance Facilitator will publish the amended version and change the date of approval and date implemented on the front page. The document Scheduled Full Review date remains the same. Changes are reported via the next available agenda at the next Policy Governance Group.

5.2 Major Changes

If a major change to a policy is required the process for a Full Scheduled Review must be followed (see section 3) with the exception that once the amendments are approved by the Governance Policy Group the document is not required to be ratified as this is undertaken as part of full scheduled review.

6 Writing a New Document

The need to develop a document is normally identified by individuals or teams or where there is a particular service development.

Before developing a new document, check if one already exists. If there is no existing document then a new document must be drafted using the process set out in this policy (sections 3 & 4).

7 Dissemination and Implementation

Once approved and ratified the author/lead is responsible for forwarding the final document, and the minutes that evidence ratification (if relevant), to the Risk and Governance Facilitator for uploading to the t-drive, together with information of any previous version of the document which requires removal as a result of the publication of the new document.

8 Process for Monitoring Compliance and Effectiveness

Compliance with all policies, guidelines (clinical and non-clinical,) procedural and competency document must be measurable and monitored. All policies, guidelines (clinical and non-clinical,) procedural and competency are monitored by the Risk and Governance Facilitator through the Corporate Governance Review Programme.

All employees have a responsibility to comply with policies and line managers have a responsibility to ensure that employees are aware of and follow policies. The document implementation lead in conjunction with Divisional Directors for a policy is responsible for ensuring mechanisms are in place to monitor compliance. This will involve monitoring the production of all new and reviewed policies against the agreed timelines.

Compliance with the Trust's policies is a requirement of employee employment contracts and the Trust's Scheme of Delegation. Non-compliance may result in disciplinary action.

9 Duties and Responsibilities of Individuals and Groups

9.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

9.2 Trust Board

The Trust Board will approve and ratify this document and its accompanying template as agreement of the standards in which centralised documents are to be held to. The Board will ensure it discharges its powers to ratify documents as part of the Scheme of Delegation.

9.3 Director of Governance and Assurance

The Director of Governance and Assurance is the responsible Director of the Corporate Governance Review Programme and will arrange for the programme to be audited as necessary both internally and externally and flag any concerns to the appropriate Committee. The Director of Governance and Assurance will approve any minor changes to documents that do not warrant a full scheduled review.

9.4 Executive Committee

The Executive Committee will receive a report from the Director of Governance and Assurance each quarter detailing the number of documents that are in date and those that have gone beyond the Scheduled Full Review date and will flag any concerns identified in the report to the relevant Divisional Director.

9.5 Governance and Assurance Committee

The Governance and Assurance Committee will receive any concerns identified within the audit carried out by the Director of Governance & Assurance and create an action plan to resolve further non-compliance.

9.6 Document Author and Document Implementation Lead

The document author/implementation lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

9.7 Target Audience – As indicated on the Cover Page of the Document

The target audience has the responsibility to ensure the compliance with this document by following the process as outlined and using the accompanying template when they are undertaking a Scheduled Full Review or making insignificant or minor changes.

9.8 Policy Governance Group (PGG)

Members of the PGG will act within the remit of this document and the Terms of Reference of PGG.

9.9 Competency Ratification Group

Competencies will be ratified by the Competency Ratification Group before they can be considered for approval. Minutes must accompany the competency as evidence that ratification has taken place. Competencies will not be added to a PGG agenda without minutes to demonstrate ratification.

9.10 Clinicians, Ward Managers, Matrons, Allied Health Care Professionals and Managers for Non Clinical Services

All Clinicians, Ward Managers, Matrons, Allied Health Care Professionals and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

10 References, Further Reading and Links to Other Policies

Where applicable, the document must contain a section detailing the research/evidence/references that were used to assist with the development of the policy. Some of this information may be included at the beginning of the document as way of an introduction but must be referenced in full at the back of the policy.

The document is to also signpost the reader to other relevant and supporting policies, ensuring that these are cross referenced within the main body of the policy were appropriate. Do not include “useful things” from other documents; instead refer to the document in its entirety.

10.1 References

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Scheme of Delegation	Intranet - Corporate Governance pages
2	The Equality Act 2010	https://www.legislation.gov.uk
3	Plain English co.uk	http://www.plainenglish.co.uk/
4	The template	T:\Trust-wide Documents\Templates and Policy Governance
5	Conduct Management Policy	T:\Trust-wide Documents
6	STAGE 2 Full Equality Impact Assessment	T:\Trust-wide Documents

11 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this policy and can be found at Appendix A

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment Template

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project?		
2.	Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet?		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?	**Yes**	**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**Yes**	**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**Yes**	**No**

Signed by the manager undertaking the assessment	
Date completed	
Job Title	

<u>On completion of Stage 1</u>: A full impact assessment will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

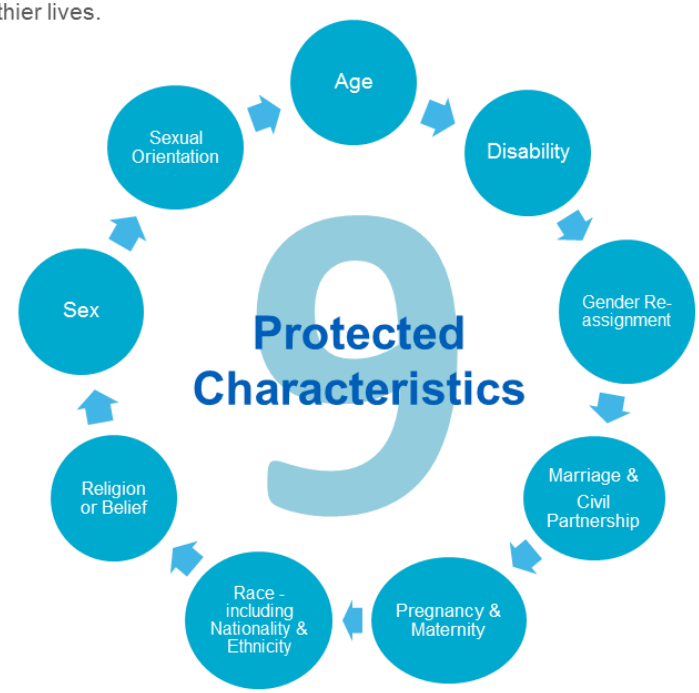
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Appendix B- Policy Template

*Content in blue italics are for guidance when using this template, and should be **deleted**.*
Fields in red italics are updated automatically or completed by the Risk and Governance Facilitator. Authors are not to complete these
*Text in green should be either **deleted or amended** as necessary but is included as a helpful guide.*

Title of the Document

Title layout to be Xyz Policy – do not use the word Policy first. Title to indicate relevant site (GWH, Community or both) and Patient Group and Age (Adults or Children).

Document No		**Version No**	
Approved by		**Date Approved**	
Ratified by		**Date Ratified**	
Date implemented (made live for use)		**Next Review Date**	
Status			
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.		All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy	
Special Cases	*Advise any cases where this document does not apply.*		
Accountable Director		*Write the job title (not the name) of Director here*	
Author/originator – Any Comments on this document should be addressed to the author		*Write the job title (not the name) of author here*	
Division and Department		*Write the Division and the department here*	
Implementation Lead		*Write the job title (not the name) of implementation lead here*	
If developed in partnership with another agency ratification details of the relevant agency		*Write the agency here*	
Regulatory Position	*This section should identify the legislation which applies in relation to the requirements of the document, i.e. is there a law or Act that dictates this document must exist. Or it should identify if there are any agencies that regulate the healthcare providers set out such as CQC.*		
Review period. This document will be fully reviewed every xxx years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Contents

Instant Information – give context in this header to explain below information

Add to *the above title (Instant Information) with a meaningful title for the context, e.g. XYZ Flow Chart or Summary of Document Contents. Do not delete the words* ***Instant Information.***

Use this initial page if you can encapsulate the important aspects of this document in a one page summary/overview or for important flow charts, tables or guideline diagrams that suit being at the beginning of the document for ease of use or ***if to be accessed in an emergency.***

Add more pages as necessary and use a meaningful header for each page.

You DO NOT Need to use this page if you do not have any flow charts, tables etc that would suit being at the beginning of your document.

Delete any unwanted Instant Information pages.
Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

1 Introduction & Purpose

This section should set the context, including reasons for the development of the document and the purpose of the document.

Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

1.2 Glossary/Definitions

This section lists and describes the meaning of the terms used in the context of the document as necessary. Always use the full description upon first mention and then the acronym can be used at any time afterwards. Add more as appropriate. Every Acronym, symbol or shortening of a word used must go in this table.

The following terms and acronyms are used within the document:

CQC	Care Quality Commission
EIA	Equality Impact Assessment
IP&C	Infection Prevention and Control
NHS	National Health Service

2 Main Document Requirements

The main content section should describe the processes. Put extraneous material in appendices. Write so the reader can learn what to do.

2.1 Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

2.2 Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

2.3 Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

Xxxxxxxxxxxxx

3 Monitoring Compliance and Effectiveness of Implementation

This should describe the process for review/monitoring both the compliance and of the effective implementation of the key aspects of the procedural document, which includes:

- *Monitoring arrangements for implementation, i.e. Audit, review, etc.;*
- *Responsibilities for conducting the monitoring/audit;*
- *Methodology to be used for monitoring/audit;*
- *Frequency of monitoring/audit, i.e. Quarterly, on a rolling basis, etc.;*
- *Process for reviewing results and ensuring improvements in performance occur.*

4 Duties and Responsibilities of Individuals and Groups

This section should give an overview of the individual, departmental and committee duties, including levels of responsibility within the organisation. It should explain who is doing what and when in relation to this policy and where responsibility lies.

***ADD or DELETE** job roles or Groups/Committees as appropriate**.** Consider the following roles and Groups. Associate Medical Director, Divisional Directors. Deputy Divisional Directors, Divisional Directors of Nursing and Heads of Service, Managers, IP&C Team, Academy Department, Finance Department, HR etc.*

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

Xxxxxxxxxxxxxx
Add further relevant duties/responsibilities or delete this role if not appropriate.

4.3 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.4 The XYZ Committee/Group

Add duties/responsibilities - who is doing what and when in relation to this document. Delete section if not appropriate.
Xxxxxxxxxxxxx

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

This should describe where the document or website can be found for the reader to look up as further reading. DO NOT put whole addresses such as https://www.gwh.nhs.uk/media/162604/cs36558_gwh_bedside_folder_v7.pdf as these links are prone to being broken just put the main addresses such as https://www.gwh.nhs.uk/

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Xxxxxxxxxxxxx	*List where the document, book or website is found*
2	Xxxxxxxxxxxxx	*List where the document, book or website is found*
3	Xxxxxxxxxxxxx	*List where the document, book or website is found*
5	Xxxxxxxxxxxxx	*List where the document, book or website is found*
4	Xxxxxxxxxxxxx	*List where the document, book or website is found*
6	Xxxxxxxxxxxxx	*List where the document, book or website is found*
7	Xxxxxxxxxxxxx	*List where the document, book or website is found*

5.2 Consultation Process

This section should set out who has been consulted in formulating this document. Appropriate stakeholders must agree the document contents before it is sent for approval. Clinical documents should also be sent to Divisional Matrons (and the Head of Midwifery if applicable). If the document is Trustwide, the relevant non acute employees must be part of the consultation process. ***If the document details actions that include catering, porters etc then Estates and Facilities providers i.e. Serco Ltd must be consulted upon****.*

Add more roles as necessary.
YOU MAY ONLY ADD A PERSONS JOB TITLE AND DATE IF THEY HAVE AGREED THE DOCUMENT. DO NOT ADD ANYONE'S DETAILS IF THEY HAVE NOT INFORMED YOU THEY AGREE THE CONTENTS.

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department ***Do not include names of individuals.***	**Date Consultee Agreed Document Contents**
Divisional Manager *(please add their job title here so it's clear who they are)*	
Swindon Community Health Services Employee *(please add their job title here {but not their name} so it's clear who they are)*	
End User *(someone that will have to use this document)* (*please add their job title here {but not their name} so it's clear who they are)*	
End User *(someone that has a role and/or responsibility as set out in this document)* (*please add their job title here {but not their name} so it's clear who they are)*	
Head of Midwifery *(if a clinical document)* (*please add their job title here {but not their name} so it's clear who they are)*	
Estates and Facilities Management *(if document refers to any cleaning, housekeeping, potering etc)* (*please add their job title here {but not their name} so it's clear who they are)*	

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project?		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet?		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?	**Yes**	**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**Yes**	**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**Yes**	**No**

Signed by the manager undertaking the assessment	
Date completed	
Job Title	

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.