London Ambulance Service NHS Trust

**Policy and Procedure for the Development and Management of Procedural Documents**

**DOCUMENT PROFILE and CONTROL.**

**Purpose of the document**: To describe in detail the system to be followed for a single approach to the effective development, implementation, monitoring and review of procedural documents.
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**Sponsor Department:** Governance Development Unit

**Author/Reviewer:** Head of Records Management & BC. To be reviewed by Jul 2010.

**Document Status:** Final

| **Amendment History** | | | |
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| Date | *Version | Author/Contributor | Amendment Details |
| 11/08/09 | 0.4 | Director of Corporate Services | Minor – Appendix 4 inserted |
| 30/07/09 | 0.3 | Head Records & BC. Head of Governance, Records Manager | Minor – scope, responsibilities, definitions, 7.5, 7.10, 8.1, appendices |
| 16/06/09 | 0.2 | Head Records & BC. Head of Governance, Records Manager | Minor – amendments made throughout |
| 17/3/09 | 0.1 | Head Records & BC | Amalgamation & revision of TP/001 & 002 |

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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| The Pulse | 09/10/09 | Records Manager | GDU |
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| Links to related documents or references providing additional information | | |
|---|---|---|
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Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

## 1. Introduction

As an organisation the London Ambulance Service NHS Trust (LAS) acknowledges that the effective management of document creation within the Trust is an essential part of good governance practice.

Effective control, management and monitoring of procedural documents (as defined in the scope (section 2) contributes to the assurance of:

- safe operations
- risk reduction
- staff awareness of current practice
- delivery of high quality patient care
- effective quality control
- transparency for external stakeholders

## 2. Scope

This policy and procedure applies to all LAS policies, procedures, protocols, strategies, and plans produced or reviewed by the Trust. It details the approach that the LAS will take in the development, management, implementation, and monitoring of these procedural documents. It also applies to guidance documents except where these are of purely a local nature.

## 3. Objectives

1. To describe in detail a single approach for the effective development, implementation, monitoring and review of procedural documents.

2. To produce procedural documents following an agreed corporate style and format.

3. To bring all procedural documents together and manage them in such a way that they will be available as part of one electronic system accessed through the Trust's intranet.

4. To define roles and responsibilities for staff, committees and groups of the Trust.

5. To define an approval, and, where appropriate, ratification route for all policies and procedures and embed full ownership and management accountability for document implementation, staff awareness, and compliance that is monitored for effectiveness.

6. To develop and consult on relevant policies and procedures in partnership with Staff Side colleagues.

## 4. Responsibilities

4.1 The LAS Information Governance Group has overall responsibility for monitoring compliance with this Policy and Procedure and the effectiveness of the system for managing procedural documents.

4.2 The LAS Trust Board, Committees and Groups have responsibility for approval, ratification and monitoring policies and procedures as detailed in Appendix 5.

4.3 Directors/Senior managers have responsibility for approving the development of new procedural documents apart from guidance of a purely local nature. They are also responsible for defining the approval process for all other procedural documents.

4.4 The Head of Records Management is responsible for operational management and development of the system.

4.5 GDU staff are responsible for the day-to-day management of procedural documents and co-ordination of the system.

4.6 Document authors are responsible for:

- ensuring that they follow this policy and procedure when developing new procedural documents;
- consulting widely with all stakeholders when developing or reviewing a document;
- ensuring that all requirements laid down by legislation and standards are considered and incorporated in their documents;
- reviewing them in a timely manner when requested by the GDU and within the timeframe specified in the procedural document itself;
- managing the review process and securing the approval of the new/ reviewed procedural document. (See appendix 5)

4.7 Managers throughout the Trust are responsible for ensuring that staff are aware of, and comply with, all relevant procedural documents.

4.8 All members of staff have a responsibility to read and be aware of the content of appropriate new and revised documentation at the earliest opportunity following issue or publication.

## 5. Definitions

5.1. Procedural Document

The term ‘procedural document’ is used throughout this document as an umbrella term for all document types within scope and as detailed below..

5.2 Policy

A policy is a high level statement of principles for action or intent that guides the decision-making and activities of the organisation and describes how an aspect of service provision or governance will be achieved.

5.3 Procedure

A written, approved specification for execution of an activity - often composed of steps, using established methods or forms - designed to achieve a uniform approach to compliance with applicable policies.

5.4 Protocol

In the context of the LAS a protocol is a convention or a predefined written procedural method which guides how an activity, normally clinical, should be performed.

5.5 Guidance

Practically advises how a task may be completed or best practice within which to work. The exercise to which the guidance applies may not be Trust wide and may vary between divisions/ departments / stations. Guidance may also be produced to supplement a procedure.

5.6 Strategy

A long term plan of action, designed to achieve a particular goal in relation to the Trust’s strategic aims.

5.7 Plans

A detailed scheme setting out a number of steps or decisions that may be followed in the future in order to achieve a certain aim or objective.

5.8 A document may be one or a combination of the above. The Records Manager will advise if required.

5.9 Consultation -the process where internal/ external Stakeholders are asked for their comments and agreement of the document. It will include groups such as staff, staff side, HR, finance, service users, *Note*: to consult does not infer negotiation.

5.10 Approval -to sanction and officially confirm that a document is appropriate to the Trust and projects the Strategic Objectives. This is carried out through the committees and groups which provide assurance to the Trust Board (See Appendix 5).

## 6. Development of documents

6.1 Any member of staff may identify a need to develop a new document or amend an existing document that affects the way services, functions and activities are performed and delivered.

6.2 All documents to be developed / reviewed must have the prior approval of the relevant **Director/ Senior Manager**. If appropriate, the relevant Human Resources Policy Lead should be involved. The **Director/ Senior Manager** will identify whether to proceed to draft with the application.

6.3 The relevant **Director/ Senior Manager** will identify an **author (Owner)** to develop the new document. The task may be delegated to a group of individuals or an appropriate manager. Staff Side representation will be included if appropriate. **The flowchart at Appendix 6 should be read by the author prior to commencement of work on the document.**

6.4 Once approval for the creation of the document is obtained, the **Director/ Senior Manager** will send an email notification to Records Management stating that approval has been given, the working title of the document and name of author.

6.5.1 The author of a document is required to consult widely with all stakeholders whenever a new document is being developed, or an existing document is due for review. The author should forward a copy of the draft to Staff Side and where appropriate the author should approach external bodies as part of the consultation process. The author will keep a record of this consultation process and notify GDU Records Management of the details of those consulted.

The document, if a policy or procedure, will then follow the agreed approvals route (see Appendix 5).

6.6 All draft documents should follow the trust document template (see Appendix 3). Note: the Implementation Plan must be completed and the Equality and Human Rights statement must be included.

6.7 The Checklist for the Review and Approval of Policies and Procedures (Appendix 1) should be completed by the author and emailed to Records Management prior to the document being submitted for approval.

6.8 Once the proposed document has reached its final draft, the author must send a copy of the document to GDU Records Management email address (RecordsManagement@lond-amb.nhs.uk).

New documents will be issued with a *Unique Reference Number by the Records Manager*, prior to being submitted for approval.

6.9 An Equality Impact Assessment (EqIA) (see Appendix 4) must be completed by the owner for each procedural document, with the exception of some guidance material. Once completed the owner must ensure that the EqIA is signed off by the appropriate Director before it is returned to the Diversity Manager with a copy to GDU Records Management. The date of completion of the EqIA will be recorded on the Document Control sheet at the front of the document. No policies/procedures will be accepted onto the agenda of a group/committee for approval without an Equality Impact Assessment in place.

6.10 The author will submit a policy or procedure for approval to the relevant committee or group (See appendix 5) and notify the Records Manager of the committee/ group and date. For all other procedural documents it will be the responsibility of the Director/ senior manager to define the approval route to be taken.

6.11 Should a procedural document require urgent approval, a committee senior to the one normally designated may take on this role.

6.12 Following approval, the author will forward the approved document to the Records Manager for conversion into a PDF read only file.

6.13 An approved master copy of the document will then be stored electronically by GDU. The document will be added to the LAS Intranet site (The Pulse) for staff to access; it will also be made publicly available through the Trust's Publication scheme on the LAS website if considered suitable for release under the Freedom of Information Act 2000 (FOIA).

The flowchart for the stages for procedural document development is at Appendix 2.

## 7. Issue, implementation and monitoring of new and revised documents

7.1 Issue

The issue of documents will be announced in the Routine Information Bulletin (RIB) by GDU who will place a full electronic version and a summary of the document on *'the pulse'* and where appropriate a copy on the LAS website. The date of the announcement will be recorded in the Document Profile and Control section. All procedural documents will normally be converted to PDF format prior to placement on the Trust's intranet and internet sites. For ease of use policies and procedures on the intranet will be bookmarked. Hyperlinks to related listed documents will be added wherever possible.

7.2 Implementation Plan and Monitoring

The Implementation Plan is an integral part of each policy and procedure and will be provided by the author. This records the intended audience, details of dissemination and distribution, communications and awareness, training to be provided if required, and monitoring of compliance. (see template at Appendix 3 for further details).

Methods of monitoring compliance will include the identification of relevant standards and key performance indicators. Policies and Procedures may also be subject to internal or external audit, to ensure full compliance is taking place as required.

To ensure effective compliance with Procedural documents the possibility of introducing an electronic system which will manage their lifecycle and enable staff to receive training on, and increase awareness and understanding of, procedural documents will be investigated.

## 8. Review system

8.1 It will be the responsibility of author/ Owner to ensure that policies and procedures and other documents that have been allocated a review period are reviewed in a timely manner. To facilitate this, the Records Manager will notify the owner three months prior to the review date and a list of document review dates will be made available on the Pulse.

8.2 Review of a document will require a further Equality Impact Assessment to be carried out if major changes are made.

8.3 The standard review period for a policy or procedure will be three years and this is the maximum period allowable before a review must take place. However, the author may decide on a shorter review period as it is the responsibility of the author of a document to ensure that it is kept up to-date, relevant and evidence based in light of best practice. The review period should also be set to reflect external requirements or anticipated changes where these are less than three years. Documents may be reviewed, following the consultation process in section 7, at any time if required. Any policy and procedure review, which in the opinion of the GDU results in only minor updates of an administrative or organisational nature, will not require further approval by the appropriate Trust committee.

## 9. Style and Format

9.1 Procedural documents will conform to the approved Trust style, as detailed on the Pulse.

9.2 The following format specification will be applied to create an approved corporate style document (see example template of a policy or procedure in Appendix 3

9.3 **Document title box** to follow the format as in Appendix 3.

9.4 All text entered in the 'Document Title' box and throughout the document to be in font style **Arial** font size 12 for both upper and lower case entries and **bold** type except for the Document Profile and Control section which will be in Arial 11. All text in the title box, headings and sub-headings should be in **bold** font.

9.5 The **Document profile and control** section must be completed by the author and the GDU as appropriate in order that version control is maintained. Authors must add references to relevant source information, policies and procedures, research data, training and guidance documents, health standards, legislation and accreditation systems that have a bearing on or relevance to the document.

9.6 Where abbreviations are used in any part of the document these will be written out in full where they first occur, immediately followed by the abbreviation typed inside brackets, e.g., London Ambulance Service NHS Trust (LAS).

## 10. Document and version control

10.1 Document Control and Archiving

The Document Profile and Control section at the start of each document provides important metadata – information on the ownership, document status and development history, version, approval, publication, and details of references and related documents.

The master documents will be electronic and maintained by the GDU in linked areas of the Trust's intranet, the Pulse. All current policies will also normally be placed in the Trust's Freedom of Information Publication Scheme on the external Website. Procedures may also be included in the Publication Scheme where there may be a particular public interest in the subject area concerned. All policies and procedures may be downloaded and/or printed from these sites but as these are controlled documents staff will no longer be issued with personal copies and they are only current at the time of download/print and are not to be regarded as definitive documents. Departmental representatives on the Information Governance Working Group will have the responsibility to check that paper files of policies and procedures and protocols are not maintained anywhere in the Trust as they can rapidly become out of date.

The GDU will maintain archived electronic copies of all superseded and obsolete policies and procedures for 25 years and previous versions are available upon application to GDU Records Management.

10.2 Version Control

Version control will be used to manage all procedural documents and will follow major or minor versions (i.e. v.1 or v1.1) format.

The GDU will allocate an alphanumeric index number to each document according to the type of document:

- **T**rust **P**olicies and procedures will commence with **TP**
- **O**perational **P**rocedures will commence **OP**
- Service forms will be allocated a new **LA** number
- **Pl**ans will commence with **PL**
- **St**rategies will commence with **ST**
- **Pr**otocols will commence with **PR**
- **Gu**idance will commence with **GU**
- **H**uman **R**esource will commence **HR**
- **H**ealth and **S**afety will commence with **HS**
- **C**ontrol **S**ervice **O**perational **P**rocedures will commence with **CSOP**

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A document control footer will be completed by the author which should contain the document reference number, the title of the document and the page number and total number of pages. For filing and archiving purposes the filename and path should be included as a footer to the document.

| IMPLEMENTATION PLAN | |
|---|---|
| **Intended Audience** | All LAS Staff |
| **Dissemination** | Available to all staff on the Pulse and to the public on the LAS website. This will be co-coordinated by the GDU. |
| **Communications** | Revised Policy and Procedure to be announced in the RIB and a link provided to the document by the GDU. |
| **Training** | It is planned to provide specific training from 2010 onwards for those members of staff who are required to develop, write and review procedural documents. GDU will co-ordinate this. |
| **Monitoring** | This policy and procedure will be monitored through the Information Governance Group (IGG). The IGG will meet quarterly and on an ad hoc basis as required.<br><br>It is expected that all documents within the defined scope will comply with this policy and procedure.<br><br>The GDU will review compliance with the policy and procedure on a quarterly basis.<br><br>To ensure compliance and effectiveness of this document, an audit of procedural documents will be undertaken every two years by the GDU. This will involve a random sample of all documents, including those archived within the previous two years. The results of the audit will be presented to the Information Governance Group who will ultimately be responsible for the development and monitoring of any identified actions within the scope of the audit. |

## Appendix 1

### Checklist for the Review and Approval of Policies and Procedures

To be completed by the owner of the document prior to submission for approval.

| | Title of document being reviewed: | Yes/No/ Unsure | Comments |
|---|---|---|---|
| **1.** | **Title** | | |
| | Is the title clear and unambiguous? | | |
| | Is it clear whether the document is a guideline, policy, protocol, procedure, strategy, plan? | | |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? | | |
| **3.** | **Development Process** | | |
| | Are individuals involved in the development identified? | | |
| | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | | |
| | Is there evidence of consultation with stakeholders and users? | | |
| **4.** | **Content** | | |
| | Is the Purpose of the document clear? | | |
| | Is the objective/s of document clear? | | |
| | Does the scope define the remit of the document? | | |
| | Are the intended outcomes described? | | |
| | Are the statements clear and unambiguous? | | |
| **5.** | **Evidence Base** | | |
| | Is the type of evidence to support the document identified explicitly? | | |
| | Are the references cited in full? | | |
| **6.** | **Approval** | | |

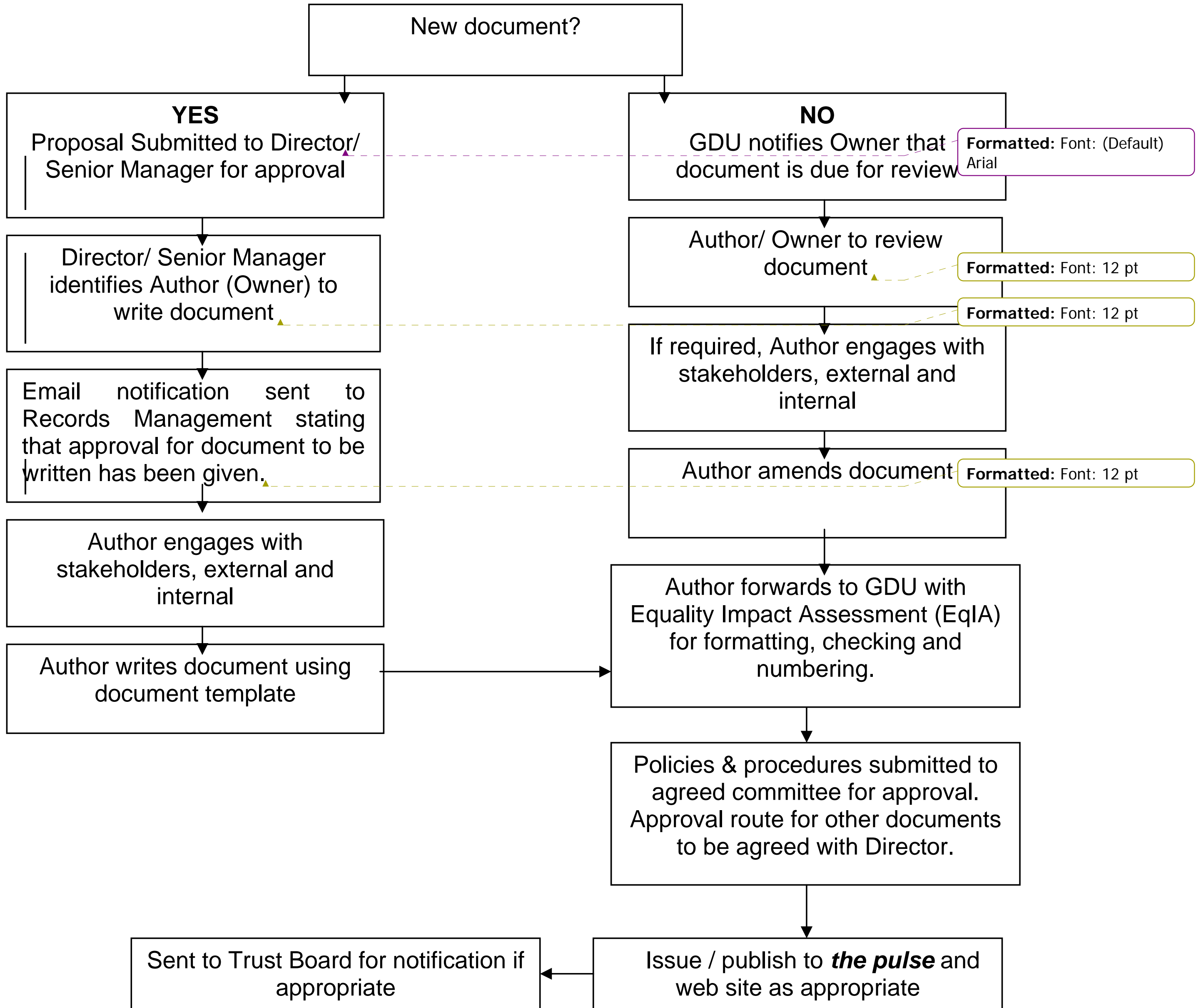
| | Title of document being reviewed: | Yes/No/ Unsure | Comments |
|---|---|---|---|
| | Does the document identify which committee/group will approve it? | | |
| **7.** | **Dissemination and implementation** | | |
| | Intended audience - Is the intended audience identified? | | |
| | Dissemination - Is it identified how the document will be made available to staff? | | |
| | Communication - Is it identified how the document (change/ creation) will be publicised? | | |
| | Training - Does the plan include the necessary training/support to ensure compliance? | | |
| | Monitoring - Are there measurable standards or KPIs to support monitoring compliance of the document? | | |
| | Monitoring - Is there a plan to review or audit compliance with the document? | | |
| **10.** | **Review date** | | |
| | Is the review date identified? | | |
| | Is the frequency of review identified? | | |
| **11.** | **Overall responsibility for the document** | | |
| | Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation? | | |

Please send completed checklist to GDU Records Management at RecordsManagement@lond-amb.nhs.uk

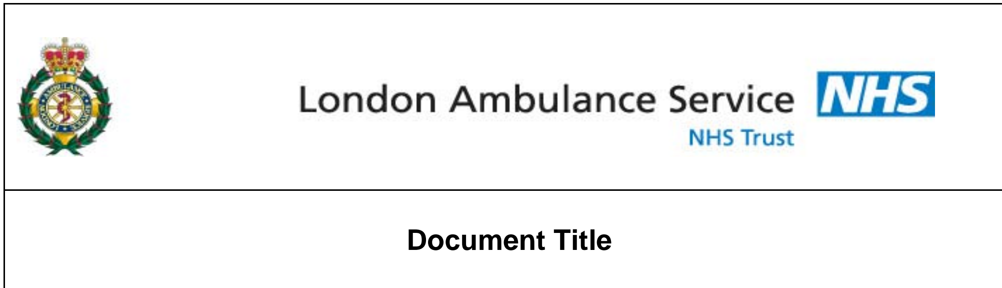
Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

**Appendix 2**

## Stages for Procedural Document Development



**Appendix 3**




**Document Title**

**DOCUMENT PROFILE and CONTROL.**

**Purpose of the document**:
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**Sponsor Department:** ***********************************

**Author/Reviewer:** ***********************************. To be reviewed by xxx 2012.

**Document Status:** Draft/ Final

| **Amendment History** | | | |
|---|---|---|---|
| Date | *Version | Author/Contributor | Amendment Details |
| XX/XX/XX | 0.2 | *************** | Minor - *************************** |
| | 0.1 | | |

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| **For Approval By:** | **Date Approved** | **Version** |
|---|---|---|
| ************* | XX/XX/XX | 1.0 |
| **Agreed by Trust Board (If appropriate):** | | |
| **************** | XX/XX/XX | |

| **Published on:** | **Date** | **By** | **Dept** |
|---|---|---|---|
| The Pulse | XX/XX/XX | Records Manager | GDU |
| LAS Website | XX/XX/XX | | |
| **Announced on:** | **Date** | **By** | **Dept** |
| The RIB | | Records Manager | GDU |

| **EqIA completed on** | **By** |
|---|---|
| | |
| **Staffside reviewed on** | **By** |
| | |

| **Links to Related documents or references providing additional information** | | |
|---|---|---|
| **Ref. No.** | **Title** | **Version** |
| | | |
| | | |

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**1. Introduction**

This provides the background narrative explaining the purpose and reason for the document.

**2. Scope**

It should be clearly stated what areas the procedural document covers and what is excluded from the coverage of the document.

**3. Objectives**

To set out concisely (by number if necessary) what the document aims to achieve and provide.

1. *******************************************************************************
2. *******************************************************************************

**4. Responsibilities**

The responsibilities and duties of postholders and committees must be clearly defined.

**Post Holder 1 -** *************************************************************
**Post holder 2 -** *************************************************************

**5. Definitions (optional)**

List and describe the meaning of terms used in the context of the document where required for clarity.

*************** **************************************************************
*************** **************************************************************

This is where the author writes the details of the specific document. There will be instances where for clarity of governance or administrative convenience a policy and procedure are combined into one document.

## 6. First Heading

6.1 ********************************************************************************

6.2 ***********************************

## 7. Second Heading

7.1 *********************************************************************************
*********************************************************************************

8.1.2*************************************

8.1.3*************************************

8.1.4*************************************

7.2. *********************************************************************************
*********************************************************************************

- *************************************
- ************************************

**Implementation Plan**

To be completed by the author

| IMPLEMENTATION PLAN TEMPLATE | | |
|---|---|---|
| | | Notes |
| **Intended Audience** | | Indicate whether the document applies to all staff or certain sections of staff |
| **Dissemination** | | Detail where document is to be made available e.g. on The Pulse and the LAS Website |
| **Communications** | | Indicate how staff will be informed of the document and made aware of its contents |
| **Training** | | If training is required indicate how this will be provided to relevant staff |
| **Monitoring** | In this section specify:<br><br>▪ Which aspect of the document will be monitored<br>▪ How that monitoring will be achieved, e.g., Audit<br>▪ Who will have the responsibility for the monitoring<br>▪ When the monitoring will take place and the frequency of it, e.g., annually in September<br>▪ How the results from the monitoring will be fed back into the document and/or monitoring process | If a policy/procedure or similar document indicate how adherence to the content will be monitored, i.e., through Internal Audit; Committee; quality checks. |

**[Appendix x]**

**Appendices.** Any standard forms, local protocols and checklists that come within the scope of the document should be numbered and referenced at the appropriate place in the text, e.g. 'see Appendix 1' Each appendix should be attached at the back of the document and numbered in bold upper case letters and figures at the top right hand corner of the page. Alternatively where documents are referred to in the text they may be accessed through electronic hyperlinks.

Appendices must be made reference to within the main body of the document. They should provide additional evidence or explanation of a subject.

## Equality Impact Assessment Guidance and Form

### Guidance

Equality impact assessments are a way of finding out whether your actions or proposals will affect some communities or groups of people differently. Such differential treatment could lead to unfair decisions and unlawful treatment by the LAS: careful and thorough assessments should help to avoid this.

Use this guide to carry out impact assessments on any functions. By functions we mean:

- policies
- services
- decision making
- action plans which accompany or form part of strategy documents
- any other activity or action you carry out.

Directories and Heads of Service must decide which of their functions will be impact assessed, based on a number of factors, including:

- the impact on external customers and if this will differ for different communities
- likelihood that staff or customers will be affected differently
- whether the function will affect relations between communities
- any statutory obligations that apply
- whether the function is specifically designed to tackle discrimination or disadvantage.
- whether the function will affect an individuals human rights

And **any function which is new, is being substantially changed, or is under review should have an impact assessment.**

The assessment is based on barriers that can exclude people or lead to some people being treated differently than others. As you go through the assessment, think about the likely effects on human rights and of the barriers on the following areas and groups:

- disabled people
- women and men
- people from black and minority ethnic communities, including refugees and asylum seekers and Gypsies and Travellers
- lesbians, gay men and bisexual people
- trans people
- older and younger people
- people of different religions and faiths
- and other groups who might not have equal access to your service.

A small group should carry out the assessment, including people who know the function well. The group should also include someone who can make sure that any actions feed in to service improvement plans, for example Heads of Service, managers and a policy, performance/ planning officer.

Keep records of your decisions and the actions needed through all eight stages of the assessment: minutes of meetings, reports or other notes. If you wish, you can use the form we have provided. Alternatively, you can structure a report of the assessment that covers the eight stages. You will probably need to refer to or make links with other documents.

The record of your completed assessment should be forwarded to your Director and or to the relevant management team for approval and comments.

**Impact assessment stages**

1. **Aims**

   Briefly outline the function that you are assessing. In two or three lines, say what it is meant to do and who will be affected by it.

2. **Fact finding**

   Gather any information that will help you to assess the function's impact on the diverse population, for example, research, statistics, performance indicators, reports from earlier consultation, monitoring results or expert knowledge. If there are any gaps in the information, decide how you will remedy this.

   You might decide to carry out some public consultation to get more information. But bear in mind that you will also need to consult later on, following the assessment stage.

3. **Assessment**

   A series of assessment questions are on page 5 of this guide.

   For the first round of assessments, officers with an equality background will be assisting teams to work through the assessment questions.

   By going through the questions you will think about whether there are any barriers to equal treatment. Whilst some barriers might only affect particular groups, you will find that many will affect a number of communities and groups. Think about whether any barriers will affect an individual's human rights.

   Then think about the actions you will take to avoid or prevent these barriers.

4. **Think of alternatives**

   If your assessment highlights serious differences in effect or treatment, you might have to do things differently.

   For plans, proposals or decisions this could mean coming up with an alternative and starting the process again.

   For services, build improvements into your action plans.

5. **Consultation**

   Find out what other people think of your ideas for actions: members of the public, service users, members of staff and staff groups, equality officers.

   Plan any consultation carefully, making sure your aims are clear from the start.

   Avoid consultation fatigue: find out first whether any similar consultation exercises have taken place and use their findings. If you do this, and feel confident that your actions will have clear benefits, you might find that you don't actually need to consult at this point.

   Make sure you consider views carefully and give feedback to people you've consulted.

6. **Action plans and targets**

   Finalise your actions, make sure they are SMART.

   Set targets for improvements.

   Ultimately, these actions should form part of your service improvement plans, where you will allocate responsibility, timescales and resources to make sure they are carried out.

7. **Monitoring and feedback**

   Decide when and how you will review your action plans and the progress against targets. This could include further consultation once a policy or change has been implemented, or arrangements to take and respond to feedback at any time.

   If issues arise that you could not have anticipated during the impact assessment, they should be picked up as part of the service improvement process. Adapt your action plans as needed to deal with these new issues, after discussing this with relevant managers or colleagues

**8. Tell people what you are doing**

Publicise your decision, service changes or new policy.

Let people know how you incorporated their opinions after you consulted them.

**Stage 3**

**Equality impact assessment questions**

These questions take you through the sorts of barriers that can make it difficult or impossible for certain groups and communities to:

- use services
- get a job or progress in a career
- benefit from policies, functions or decisions
- find out about what the London Ambulance Service does
- get their opinions heard.

Think about the current situation and your plans for the future. Will your policies, plans or decisions make things better or worse for some groups? What will you do to improve things?

**Built environment**

Are the buildings, premises and environment easy for everyone to find, get into or use? Are they accessible, safe and user-friendly?

Example: A planned office move must take into account the needs of disabled staff, both current staff and those who might be recruited in future.

**Location of premises and services**

Are some communities particularly well or badly served by the location of your premises? Are you changing the location or reducing the number of premises? What effect will this have?

Example: A Health Service Unit closure should not disadvantage service users from communities which are concentrated in particular parts of the city, for example if their travelling distance to the Health Unit would be significantly longer than for other service users.

**Information and communication**

Do you have a strategy that makes communication as accessible to as many people as possible?

Does it include written, face to face, telephone and electronic communication?

Will information reach as wide an audience as possible?

Example: Staff producing a newsletter should have carefully considered their audience at the start. Decisions about translation, formats and distribution will follow from this.

**Customer care and staff training**

Have all staff who deal with the public been trained to provide a service to diverse communities?

Do all managers know what their legal responsibilities are?

Are there any particular training needs for specific services or arising from a change of policy?

Example: Reception staff know how to book interpreters if needed and have clear, written instructions available.

**Stereotypes and assumptions**

Are functions or services based on knowledge, assumptions or stereotypes that might exclude some people, families or partners? Have functions or services been developed around a particular type of service user or an “ideal” service user?

Example: Staff carry out an audit of their leaflets and forms to make sure they can be used by single parents or carers and same sex couples, not just heterosexual couples.

**Timing**

Do your opening times, appointment and waiting systems, timescales or deadlines suit everyone?

Example: An open day should be planned so that it doesn’t clash with any religious festivals.

**Costs of the service**

If people have to pay for a service, or if a service provides particular benefits or concessions, is this fair for everyone?

Are there extra or hidden costs for some people?

How will changes to these costs affect different groups?

Example: Leisure centres give free entry for carers or support workers who assist disabled people. This means that disabled people who need assistance do not have to pay for two people.

**Commenting on the function: consultation**

Do you have a plan for consultation?

Does it include:

- clear reasons for carrying out consultation?
- consulting with and getting feedback from a range of communities, organisations and individuals?
- using the most appropriate and accessible methods?
- using results from previous consultations?
- consulting with people who use services and those who don't?

**Barriers that are specific to the function**

Are there any other barriers that haven't been covered? These could be specific to the function or type of function.

Example: A varied menu at an event provides for a range of diets.

## Equality Impact Form

Function/ policy being assessed: -------------------------------------------------------

Directory/ service or corporate function: ------------------------------------------------

Date of assessment: ------------/--------/-------------------------------------------------

Contact person for the assessment: ---------------------------------------------------

Members of the assessment group:--------------------------------------------------------------
----------------------------------------------------------------------------------------------------------
--------------------------------------------------------------------------------

### 1. Aims of the function/ policy

## 2. Current achievements and fact finding

Sources of information used, with references, location or links.
Anything you have learnt from previous consultation results with references or links. In particular any evidence you may have that impacts upon: **race, disability, gender, age, religion and belief, sexual orientation and human rights**

**3. Assessment and actions needed**

Initial ideas for actions can go here. You will refine them further at stage 6. Please note the impact assessment will not be accepted unless group(s) affected is listed with a link to the action required. Primary areas to consider are: **race, disability, gender, age, religion and belief, sexual orientation and human rights**

| Barrier | Group affected | Action needed | Responsibility | Timescale | Resources |
|---|---|---|---|---|---|
| Built environment | | | | | |
| Location | | | | | |
| Information and communication | | | | | |
| Customer care and staff training | | | | | |
| Timing | | | | | |
| Stereotypes and assumptions | | | | | |
| Costs of the service | | | | | |
| Commenting, consultation | | | | | |
| Specific barriers | | | | | |
| Human Rights | | | | | |
| Other | | | | | |

**5. Future consultation**

Plans and aims for further consultation.

Who with, when, method of consultation.

**6. Action plans, targets and priorities**

Explain how the action plan will tie into service improvement plans, directorate action plans and local delivery plans

**7. Monitoring and feedback**

Details of how you will review action plans and progress. **All impact assessment action plans must be reported back internally and to the equality and diversity facilitators 6 monthly as a minimum.**

**8 Tell people what you are doing**

Information on how you will publicise decisions, actions and service improvements. How will you make this available to the public?

**Appendix 5**

## Policy and Procedure Approval Process

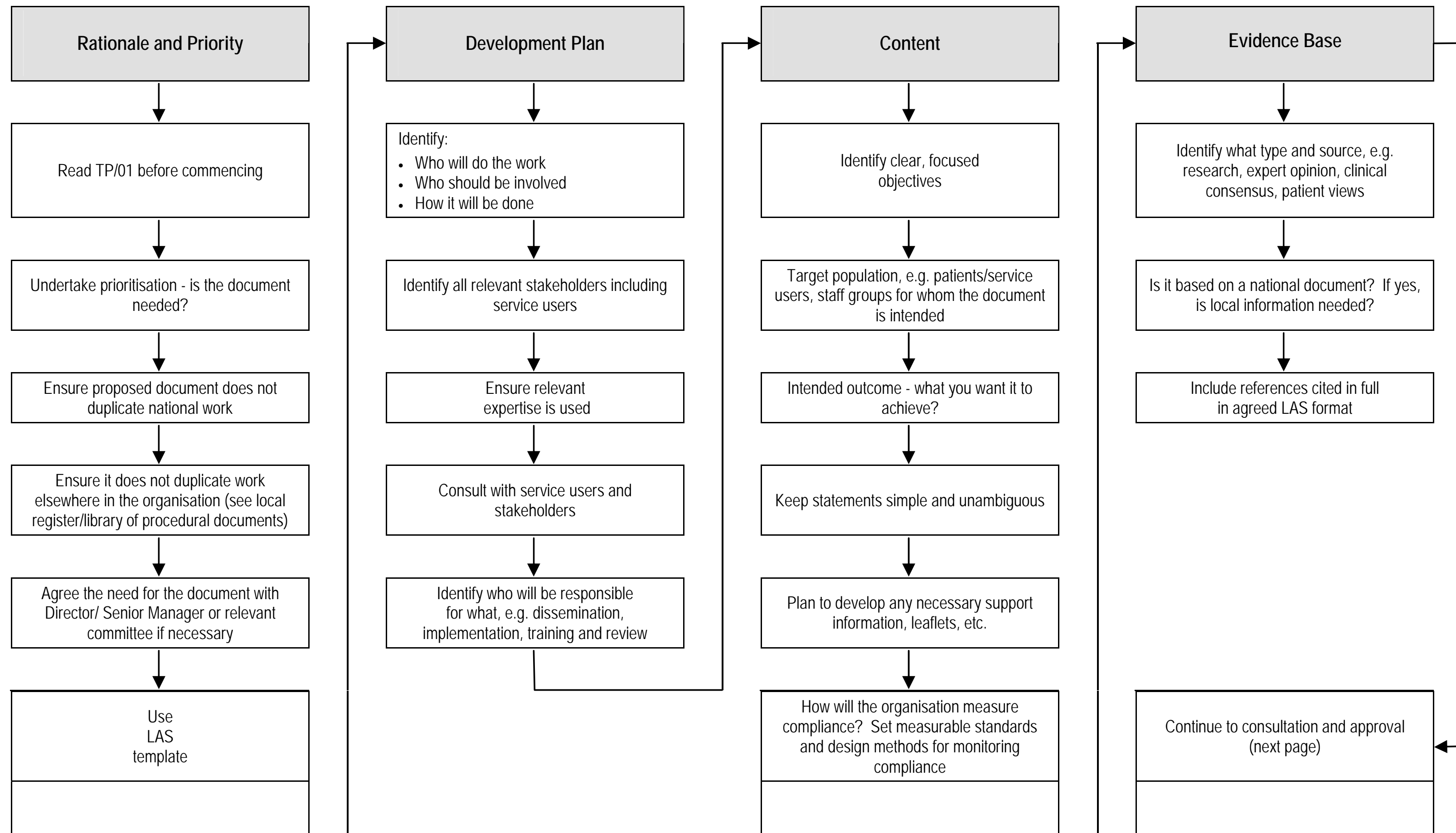
| Type | Director/ Owner | Joint Consultation – Staff Council/ CH&SC | Approving Committee |
|---|---|---|---|
| Finance, Audit, Fraud | Director of Finance | No | SMG then Audit Committee |
| Non Health & Safety Risk including Assurance Framework, and legal | Director of Corporate Services | No | Risk Compliance and Assurance group then Audit Committee |
| Business Continuity, vehicle and equipment risks | Director of Finance | | Audit Committee |
| Procedural documents which relate to clinical matters including infection control | Medical Director | Yes | Clinical Governance Committee<br>Infection control policies and related procedural documents should be signed off by the Infection Control Group first. |
| IM&T and Information Governance including Records Management, Data Protection and Freedom of Information | Director of IM&T & Medical Director | No | Information Governance Group |
| A&E Ops, Control Services, PTS, Logistics | Director of A&E Operations | Yes | Senior Management Group (SMG) |
| HR, Training, Diversity | Director of HR & Organisation Development | Yes | Senior Management Group (SMG) |
| Health and Safety | Director of HR & Organisation Development | Yes | Corporate health and Safety Group |
| Complaints, SUIs | Deputy Chief Executive | Yes | Feedback Learning & Improvements Group then RCAG |
| Driving & care of Trust vehicles | | No | Motor Risk Group |
| Emergency Preparedness | Director of A&E Operations | Yes | Emergency Preparedness Strategy Group |
| Other, not covered by above. | As appropriate | As appropriate | As appropriate |

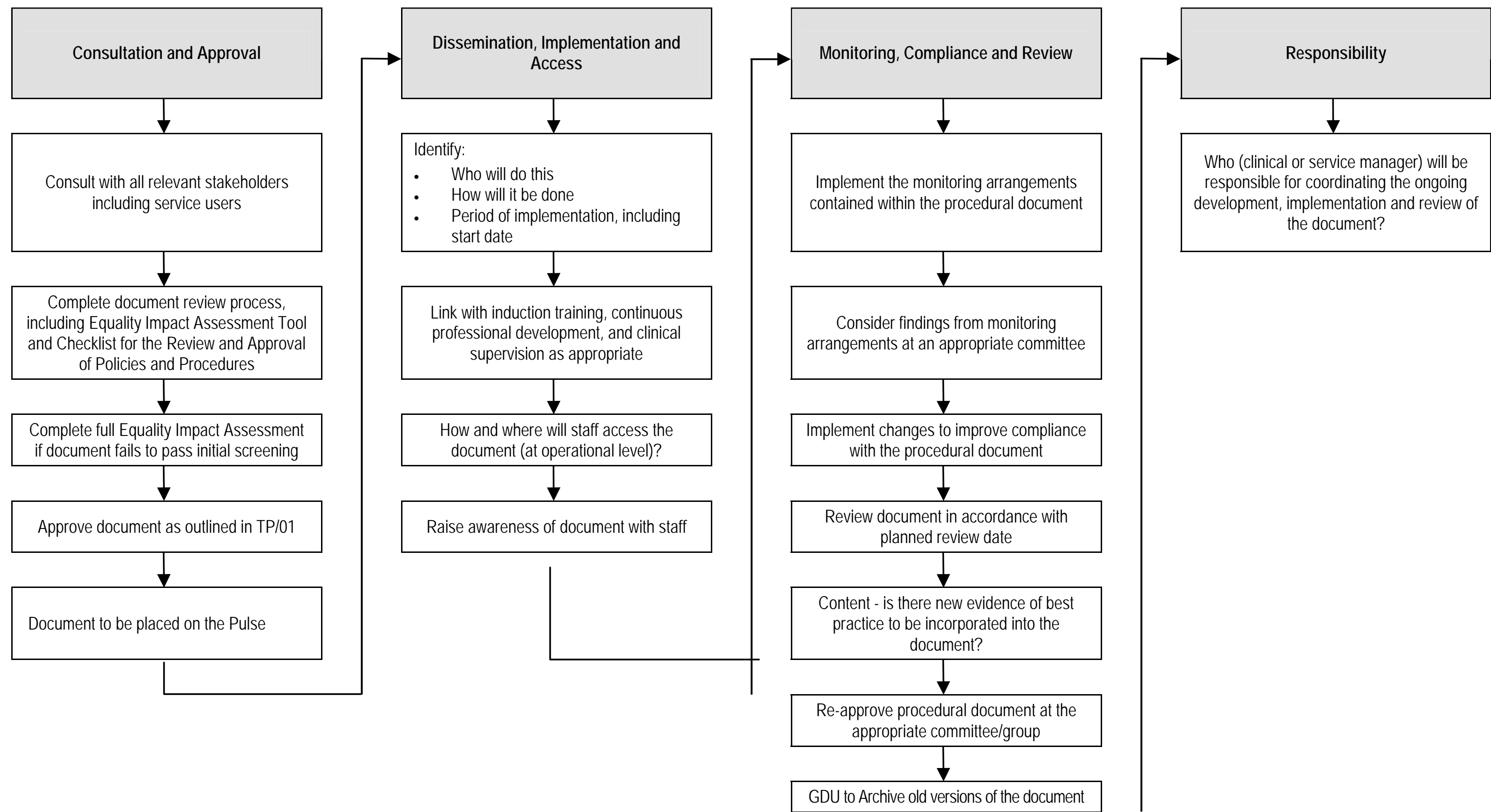
The approval route laid down in this table is applicable only to policies and procedures of the Trust. For all other procedural documents the approval process will be decided by the Director/senior manager sponsoring the document.

A few policies, such as Risk Management and Infection Control, will need to be approved by the Trust Board.

In some cases policies and procedures may also need to be ratified by a higher Committee/Group.

## Flowchart for the Creation and Implementation of Procedural Documents    Appendix 6




Consultation and Approval
Consult with all relevant stakeholders including service users
Complete document review process, including Equality Impact Assessment Tool and Checklist for the Review and Approval of Policies and Procedures
Complete full Equality Impact Assessment if document fails to pass initial screening
Approve document as outlined in TP/01
Document to be placed on the Pulse
Dissemination, Implementation and Access
Identify:
• Who will do this
• How will it be done
• Period of implementation, including start date
Link with induction training, continuous professional development, and clinical supervision as appropriate
How and where will staff access the document (at operational level)?
Raise awareness of document with staff
Monitoring, Compliance and Review
Implement the monitoring arrangements contained within the procedural document
Consider findings from monitoring arrangements at an appropriate committee
Implement changes to improve compliance with the procedural document
Review document in accordance with planned review date
Content - is there new evidence of best practice to be incorporated into the document?
Re-approve procedural document at the appropriate committee/group
GDU to Archive old versions of the document
Responsibility
Who (clinical or service manager) will be responsible for coordinating the ongoing development, implementation and review of the document?