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.

Sponsor Department: Governance Development Unit

Author/Reviewer: Head of Records Management & BC. To be reviewed by September 2011.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
06/09/10	1.6	Director of Corporate Services & Head of RM	New S.6.12; Revised Appendix 4
16/08/10	1.5	Head of RM	Appendix 1 & S.6.7 removed. New section 6.11 added. S. 8.1 revised. Monitoring section revised.
14/06/10	1.4	Head of RM	Appendix 5 further revised; section 6.11 and Appendix 2 revised
24/05/10	1.3	Head of RM	New section 6.10 on Privacy Impact Assessments added.
21/05/10	1.2	Director of Corporate Services, Head of Records Management and Business Continuity	Revised appendix 5
16/03/10	1.1	Equality and Inclusion Manager	Revised appendix 4, LA035
11/08/09	0.4	Director of Corporate Services	Appendix 4 inserted
30/07/09	0.3	Head Records & BC. Head of Governance, Records Manager	scope, responsibilities, definitions, 7.5, 7.10, 8.1, appendices
16/06/09	0.2	Head Records & BC. Head of Governance, Records Manager	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.

For approval by:	Date approved	Version
SMG	15/09/10	2.0
SMG	19/08/09	1.0
Agreed by Trust Board (If appropriate):		
Trust Board	29/09/09	1.0

Published on:	Date	By	Dept
The Pulse	08/10/10	Governance Administrator	GCT
LAS Website	08/10/10	Governance Administrator	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB	10/10	Governance Administrator	GCT

EqIA completed on	By
27/09/10	Director of Corporate Services
Staffside reviewed on	**By**

Links to related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/029	LAS Records Management Policy	

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 4.

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 The Governance and Compliance 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 Governance and Compliance department 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 4)

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 4).

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 5 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 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 Records Management of the details of those consulted.

The document, if a policy or procedure, will then follow the agreed approvals route (see Appendix 4).

6.6 All draft documents should follow the trust document template (see Appendix 2). Note: the Implementation Plan must be completed.

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

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

6.8 An Equality Impact Assessment (EqIA) (see Appendix 3) 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 Equality and Inclusion Manager with a copy to 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 normally be accepted onto the agenda of a group/committee for approval without an Equality Impact Assessment in place.

6.9 If a procedural document is developed as a result of a new project the author should check with the project manager to see whether an Initial Privacy Impact Assessment has been carried out. If not, it is the responsibility of the project manager to carry this out before any related procedural document is approved.

6.10 The author will follow the Policy and Procedure Approval Process as detailed in Appendix 4. Procedural documents as indicated by column 3 will be submitted to Staff Side by the owner as appropriate. Once Staff Side input has been obtained and any necessary changes made the owner will submit a policy or procedure for approval to the relevant committee or group and notify Records Management 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 All policies and procedures developed or reviewed within the Operations Directorate will initially be tabled at the weekly ADOs meeting for discussion and agreement. Following agreement the document will be presented by the lead Assistant Director/Head of Department (or equivalent) to the next Assistant Directors' Group (ADG) meeting for approval. If it is a new policy/procedure or one that has been substantially changed the document, once approved, will be sent to SMG for ratification.

6.12 The Assistant Directors' Group will produce a monthly report for the SMG on policies reviewed and those approved.

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

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

6.15 An approved master copy of the document will then be stored electronically by the Governance and Compliance department. 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 1.

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 Governance and Compliance 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 2 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 Records Management will notify the owner six months prior to the review date and a list of document review dates will be made available on the Pulse. If after three months prior to the review date no progress has been made the owner will receive a reminder email with a copy sent to the sponsor.

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 Governance and Compliance department 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 2.

9.3 **Document title box** to follow the format as in Appendix 2.

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 Governance and Compliance department 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 Governance and Compliance department 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 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 Governance and Compliance department will maintain archived electronic copies of all superseded and obsolete policies and procedures for 25 years and previous versions are available upon application to 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 Records Manager 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**

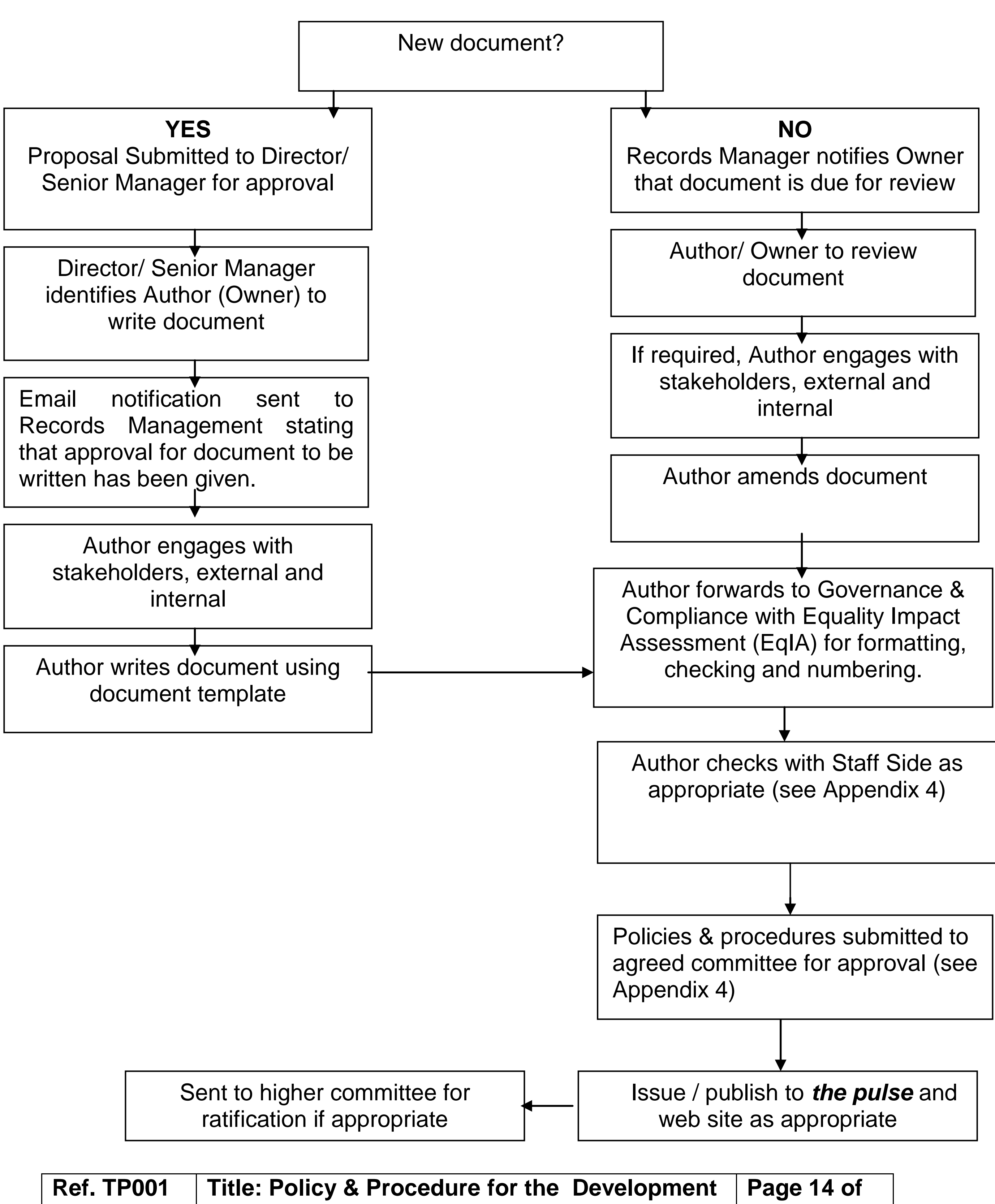
A document control footer will be completed by the author which should contain the document reference number, the title of the document and the page number and total number of pages. For filing and archiving purposes the filename and path should be included as a footer to the document.

Implementation Plan

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 Governance and Compliance Team.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document by the Governance Compliance department.
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. Governance and Compliance Team.will co-ordinate this.
Monitoring	It is expected that all documents within the defined scope will comply with this policy and procedure. The Policy and Procedure Approval Process will be monitored on an annual basis by the Head of Records Management and a report compiled on the effectiveness of the process and any changes required will be made to the Information Governance Group An audit of the procedural documents management system will be undertaken every two years by Internal Audit to check that this policy and procedure is being followed. 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. The Information Governance Group (IGG) reports through to the Risk Compliance and Assurance Group who will monitor outcomes and recommendations from these reports.

Appendix 1

Stages for Procedural Document Development



Appendix 2

London Ambulance Service NHS NHS Trust
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		

***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.

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	GCT
LAS Website	XX/XX/XX	Records Manager	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB		Records Manager	GCT

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 ***
****

7.1.2*************************************

7.1.3*************************************

7.1.4*************************************

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: ***List aspects/Key elements of the policy that will be monitored,*** *e.g., training records, employment checks, etc* ***What tool will be used and how often will this take place*** *,e.g., annual audit of x, monthly report, quarterly statistical analysis of x, weekly inspection of x, etc* ***Who is responsible for carrying this out? Title of individual/team that will do this,*** *e.g., Head of Legal Service, Director of Finance, Clinical Audit Team, etc* ***Name of Group/committee where the results will be reported,*** *e.g., Learning from Experience Group, Information Governance Group, Infection Control Steering Group, Assessment Steering Group, HR, H&S, etc* ***Who monitors outcomes/ recommendations?*** ***Name of Higher level group/committee that will monitor outcomes/ recommendations and how learning will take place****, e.g., Trust Board, Audit Committee, RCAG, Quality Committee, Clinical Safety and Effectiveness Committee*

[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.

Appendix 3

LA035

Equality Impact Assessment Guidance and Form

We need to undertake Equality Impact Assessments because:

- All public bodies need to carry out Equality Impact Assessments of their policies, services, functions, etc. in line with equalities legislation.
- We need to make sure that we are properly serving our diverse local communities and our services are accessible to all
- Equality impact assessments actively support the delivery of our Equality & Inclusion Strategy and Policy and help us meet our equality & inclusion objectives, as a service provider, procurer of services, employer & decision making body

What is an Equality Impact Assessment?

An Equality Impact Assessment is a systematic way of looking at current or proposed policies, services, functions etc. to identify the effect they have on different equality strand groups. Equality Impact Assessments help you to anticipate any consequences of your policies, services and functions etc. so that as far as possible any negative consequences for any equality strand group can be eliminated, minimised or counterbalanced by other measures. They also provide you with an opportunity to promote positive outcomes, such as positive relations between different racial groups and more targeted services.

When should you undertake an Equality Impact Assessment?

- During the early stages of developing your policy, service, function etc. so that it can help you become aware of any relevant information, which will enhance your policy/service development
- During a review of your policy etc – it will enable you to identify any relevant equality & inclusion issues as well as making you aware of any opportunities to promote equality & inclusion

Why else should we carry out Equality Impact Assessments?

They help us to:

- Identify whether we are excluding any equality strand groups or individuals from the benefits of our policies, functions, services etc.
- Identify any direct or indirect discrimination
- Consider any alternatives to address any adverse impact arising and exploit all opportunities to seek positive benefits, such as improving community relations, addressing health inequalities etc.
- Integrate equality & inclusion into all our policymaking and service delivery
- Focus our services and resources more efficiently and thus improve the quality of our services, employment, decision making and engagement
- Demonstrate to our regulators our systematic and holistic approach to equality & inclusion

It is also a requirement under equalities legislation:

- The Race Relations (Amendment) Act 2000 placed a duty on public bodies to produce a Race Equality Scheme and to carry out Equality Impact Assessments of proposed and existing policies, functions and services etc. in order to identify and address any adverse impact. Results were to be published and any agreed actions implemented and monitored.
- The Disability Discrimination Act 2005 (DDA) put a duty on public bodies to eliminate discrimination against disabled people and promote disability equality in access to services, service delivery and employment, requiring public bodies to produce a Disability Equality Scheme, which set out actions to promote equality of opportunity for disabled people. Additionally, public authorities were required to involve disabled people in policy development.

- The Equality Act 2006 introduced a new public duty aimed at eliminating discrimination on the grounds of gender and promoting gender equality. Public authorities were required to produce a Gender Equality Scheme, including an equal pay policy and audit and to tackle occupational segregation; the remit included women, men and transsexual people. This Act also extended the duty on public bodies not to discriminate on the grounds of sexual orientation or religion or belief in relation to the provision of goods, facilities and services, education and the carrying out of public functions.

- Employment Equality Regulations: The Employment Equality Regulations (Religion or Belief) came into force on December 2 2003; the remit of this legislation also included anyone with no religion or belief. The Employment Equality (Sexual Orientation) Regulations came into force on December 1 2003; in these regulations sexual orientation was defined as being a sexual orientation towards either persons of the same sex, persons of the opposite sex or persons of the same sex and of the opposite sex. The Employment Equality (Age) Regulations came into force on October 1 2006; these regulations carried implications for the employment of younger and older people.

What else will Equality Impact Assessments help us to achieve?

We will not undertake equality impact assessments purely to satisfy our statutory duties as a public body and NHS Trust. We want to be innovative in the way we carry them out, to make them into a business tool to change health outcomes for our patients and customers for the better, improve our employment practices for our staff and become a more inclusive decision making organisation, which actively and holistically engages with all our diverse communities. Carrying out equality impact assessments will help show how we are making progress against the Care Quality Commission standards. It will also help us to ensure that we work within a human rights framework of equality and fairness, dignity and respect for all.

Whose responsibility is it?

Whenever a review of a policy or service etc. is required, the manager responsible for that policy or service is responsible for carrying out the equality impact assessment. She/he needs to get a team of people together to do the equality impact assessment together and arrange in advance of the equality impact assessment for all team members to access the equality impact assessment training. This team should include a "critical friend", someone outside the work area (this could be a service user, staff side representative or relevant colleague from a different department). Carrying out equality impact assessments as a team not only will enable you to develop any ideas you have about the policy or service better, it will also allow you to have a more holistic idea of its impact, since the project team will bring together different experiences. The equality impact assessment should be

entered into the online e-tool, with each section agreed by the team. It may be that the specific policy/function/service etc. is closely connected to another one within the service; in this case, it may make sense to undertake a joint equality impact assessment.

What are the possible outcomes of your equality impact assessment?

Your assessment should show that you have reached one of three possible outcomes:

Outcome A – Your policy/service/function is not likely to result in any adverse impact for any equality strand group and promotes equality of opportunity.

Action - You need to have the completed equality impact assessment approved by your Director, stored in Sharepoint and sent through to the Communications Team for publication on the Trust's website. You still need to ensure you complete the monitoring and review section in this proforma to enable you to check that any desired outcomes are delivered.

Outcome B – The impact assessment shows that your policy/service/function is not likely to result in any adverse impact for any equality strand group but equally does not promote equality of opportunity.

Action – As a member of an NHS Trust dedicated to continuously improving its services and organisational practice, you should look further to see if there is any lawful positive impact which could be delivered and discuss this with members of your project team. If there are any relevant actions which could be taken, please include them in the Action Plan, then follow the same steps as Outcome A.

Outcome C – The impact assessment shows that your policy/service/function is likely to have an adverse impact on particular equality strand groups or individuals.

Action – You need to consider whether the policy/service/function is lawful, for which you may need specialist advice and if not then how to mitigate or eliminate any adverse impact. This may involve:

- Finding another way to meet your policy or service objectives

- Adapting the policy/function/service etc. so that any adverse impact is removed

- If the impact assessment shows that some groups within equality strand groups face particular barriers or have different needs, identifying whether these can be addressed either through changing the policy/function/service or through another way

Action Planning

Any actions you have identified which need to be carried out need to be put into your action plan, showing who will be responsible for carrying them out and the timescales.

Monitoring and Review

You will need to monitor your action plan to ensure the actions included have been carried out and have achieved their intended outcomes. After three years you need to revisit your impact assessment as a matter of good practice; this needs to happen sooner if there are any changes to your policy/service/function which might result in adverse impact on any of the equality strand groups.

What happens once you have completed your equality impact assessment?

The manager, whose service/policy/function is being impact assessed, needs to send this through to her/his Service Director for approval. The impact assessment then should be placed on the relevant shared drive and simultaneously sent through to the Communications Team for publication on the Trust's website.

Who can help if you have any queries?

The Equality Impact Assessment e-tool has prompts and learning points to assist managers and teams with completion of the impact assessment. The Equality Impact Assessment face-to-face training will take staff through specific areas of difficulty/importance and a range of relevant scenarios. For any further assistance, please contact the Equality & Inclusion Team.

Further information on equality impact assessments can be found at:

- A Practical Guide to Equality Monitoring (Department of Health – www.dh.gov.uk/dr_consum_dh_digitalassets?@adh/@en/documents/digitalasset/dh_4116843

Initial Screening Tool

Title of policy/service/function/procedure/ programme/ or strategy being assessed:

Is it new ☐ or revised ☐

(**If revised, please attach a copy of the original Equality Impact Assessment.)**

Senior Manager Responsible____

Department ____

Section ____

Equality Impact Assessment Screening Team

Name	Department	Role

Date of screening ____

Please summaries below the aims and objectives of this policy/service/function etc. including any intended outcomes.

Please state below who is intended to benefit from this policy/service/function etc. and in what way.

Please state in the table below whether the policy/service/function etc. could have any potential impact on any of the equality strand groups, whether service users, staff or other stakeholders

Equality Strand Group	Is there likely to be a positive or neutral impact in regard to:	If the impact is adverse, can this be justified on the grounds of promoting equality of opportunity for an equality strand group or for another reason?
Age		
Disability		
Gender		
Race		
Religion or Belief		
Sexual Orientation		

Please provide and summarise below any relevant evidence for your declaration above – this could include for example the results of specific consultations, complaints or compliments, customer satisfaction or other surveys, service monitoring and take-up, comments from stakeholders and demographic data.

Are there any gaps in the evidence you have which make it difficult for you to determine whether there would be an adverse impact?

No ☐ **Yes** ☐

If yes, please state below how you intend to acquire this evidence and your timescales for doing so.

If you have identified a positive or negative potential impact for any equality strand group, which is not legal or justifiable, then you must complete a full Equality Impact Assessment. Please insert below any issues you have identified/recommendations for the full Equality Impact Assessment.

If you have only identified a neutral or positive impact on any equality strand group then no further action is required, other than having your Director sign off this form, a copy stored on the shared drive and sent to Communications for publication on the Trust's website.

Name of Director: Signature: Date:

Full Equality Impact Assessment Tool

Senior Manager responsible ____

Department ____

Contact no ____

Email ____

Equality Impact Assessment Project Team

Please enter below the names of the project team members who carried out this impact assessment with you and their role in the impact assessment (e.g. team colleague or critical friend).

Name	Department	Role
		CRITICAL FRIEND

Date of completion of the Equality Impact Assessment ____

From the initial screening undertaken please state below:

Key aims of the function/ policy/ service etc.

Its intended benefits and for which equality strand groups

Any issues/recommendations identified in your screening

The evidence you are using for this impact assessment

Based on the initial screening, please state below what the positive/negative impact is on equality strand groups

Equality Strand Group	Positive/negative impact	If there is an adverse impact, can it be justified on the grounds of promoting equality of opportunity for an equality strand group or for any other reason?	Please set out the steps you will take to remedy any adverse impact and include them in your Action Plan.
Age			
Disability			
Gender			
Race			
Religion/belief			
Sexual Orientation			

Please state when and how you will monitor and review this policy/function/service etc.

Please insert into the Action Plan below any relevant activities you have identified from the impact assessment

Action	Staff member responsible	Timescale	Outcome

Supporting Documentation

Please refer to any relevant documentation you have used in carrying out this impact assessment (including reports, surveys, publicity materials etc. where appropriate)

Appendix 4

Policy and Procedure Approval Process

Subject	Director/ Sponsor	Joint Consultation – Staff Council/ CH&SC	Reviewing/ Approval Committee	Ratification (if required)
Finance, Audit, Fraud	Director of Finance	No	Senior Management Group (SMG)	Audit Committee
Non Health & Safety Risk including Assurance Framework, and legal	Director of Corporate Services	No	Risk Compliance and Assurance Group	Quality Committee
Vehicle and equipment risks	Director of Finance	Yes	Vehicle Equipment Working Group (JT)	Senior Management Group (SMG)
Clinical / medical (except infection control)	Director of Health Promotion and Quality (initially Medical Director)	No	Clinical Quality, Safety and Effectiveness Committee	Quality Committee
Infection control	Director of Health Promotion and Quality (initially Medical Director)	Yes	Infection Control (JT)	Clinical Quality, Safety and Effectiveness Committee
IM&T and Information Governance including Records Management, Data Protection and Freedom of Information	Director of IM&T (SIRO), Medical Director (Caldicott Guardian), and Director of Corporate Services	No	Information Governance Group	Risk Compliance and Assurance Group
Operations (Areas, Control Services, Central Operations, Logistics, Fleet, Emergency Preparedness and Business Continuity)	Director of Operations	Yes	a) Associate Directors' Group (ADG) b) Senior Management Group (SMG)	Senior Management Group (SMG)
HR	Director of HR & Organisation Development	Yes	a) Associate Directors' Group (ADG) b) Senior Management Group (SMG)	a) Senior Management Group (SMG) b) Trust Board

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Type	Director/ Owner	Joint Consultation – Staff Council/ CH&SC	Reviewing Committee	Approval by
Terms and Conditions of Employment/ working practices	Director of HR & Organisation Development	Yes	Staff Council	SMG
Training	Director of HR & Organisation Development	No	Training Strategy Group	Risk Compliance and Assurance Group
Equality	Director of HR & Organisation Development	Yes	Equality and Inclusion Group (JT)	Senior Management Group (SMG)
Health and Safety	Director of HR & Organisation Development	Yes	Corporate Health and Safety Group (JT)	Risk Compliance and Assurance Group
Complaints, SUIs	Director of Corporate Services	No	Learning from Experience Group	Quality Committee
Driving & Care of Trust vehicles	Director of Finance	Yes	Motor Risk Group (JT)	Risk Compliance and Assurance Group
Other, not covered by above.	As appropriate	As appropriate	As appropriate	As appropriate

NOTES

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.

The ADG committee is newly established in 2010/11 and its role in policy review and approval will be monitored during the year and will be included in the overall governance (committee) review in April 2011.

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JT = a Joint Management/ Staff Side Group

Whether or to what extent there is formal consultation on any individual matter will be influenced by the reason for the policy or change to policy:

- Where a response to new or changed legislation, draft to be shared but scope for formal consultation will be limited at best.
- Where simply a minor change or update, share for information and comment but formal consultation may not be required.
- Significant change or new working practice or procedure – formal consultation.

The constitution of the Trust's joint Staff Council indicates that the following matters will be subject to consultation and/or negotiation as indicated:

Consultation

- Trust strategy
- Operational and financial performance
- Workforce and business planning
- Commissioning and Funding
- Health and Safety
- Working patterns
- Patterns of service delivery/working practices
- Vehicles and equipment
- Staff facilities
- Estate
- Staff uniforms
- Development and training
- Equalities and Diversity
- Flexible working/family friendly policies
- Security of employment/redundancy
- Disciplinary/Grievance procedures

Negotiation

- Changes to conditions of employment

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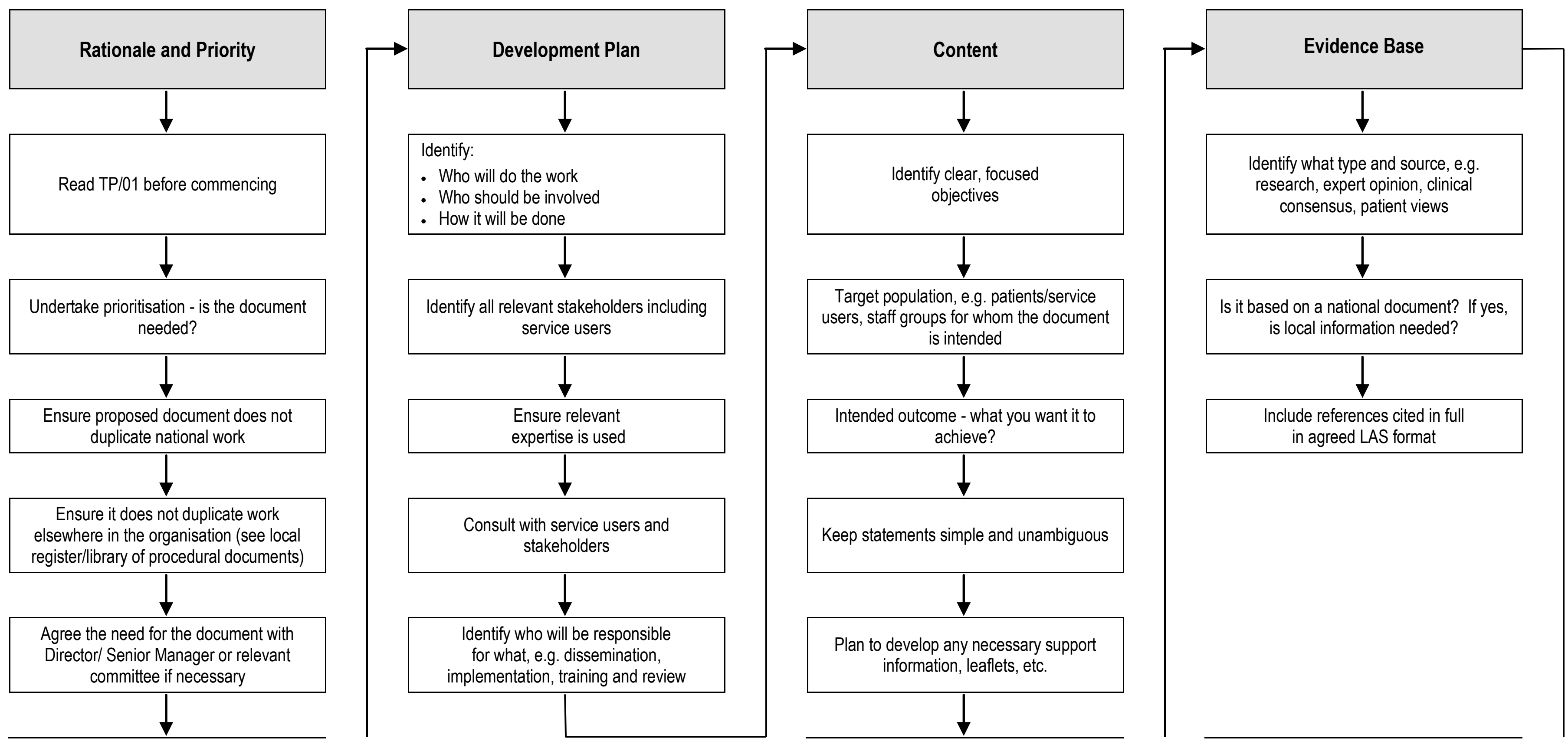
- Changes to working practices where these have implications for the contract of employment.
- Disputes Procedures

The above lists are not intended to be exhaustive.

Appendix 5

Flowchart for the Creation and Implementation of Procedural Documents



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Use
LAS
template

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

How will the organisation measure compliance? Set measurable standards and design methods for monitoring compliance

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

GCT to Archive old versions of the document

Continue to consultation and approval (next page)

Responsibility

Who (clinical or service manager) will be responsible for coordinating the ongoing development, implementation and review of the document?

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