Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

POLICY DEVELOPMENT AND MANAGEMENT

POLICY NO & CATEGORY	**CG 01**	**Corporate Governance**
VERSION NO & DATE	12	January 2017
RATIFYING COMMITTEE	Clinical Governance Committee	
DATE RATIFIED	February 2017	
NEXT ANTICIPATED REVIEW DATE	February 2020	
EXECUTIVE DIRECTOR	Executive Director of Nursing	
POLICY LEAD	Associate Director of Governance	
POLICY AUTHOR *(if different from above)*	Head of Compliance	
FORMULATED VIA	Working group / Clinical Governance Committee	

POLICY CONTEXT:

- This policy sets out the framework for the development and ratification of all Trust Policies.
- This is relevant to ALL staff in all Locations.

POLICY REQUIREMENT (see Section 2)

- All policies and procedures within the Trust will be developed, agreed and implemented in accordance with this standard policy.
- All managers have a responsibility to ensure that staff, are aware of key policies which impact on their roles and should ensure that all staff are able to access any Trust policy, and receive appropriate training and support to ensure that policies can be complied with.
- Policy writers should ensure that policies can be easily followed and understood by all staff that may have to read them. For this reason policies should be short and written in plain English.
- All Policies are required to be approved by a senior 'ratifying' committee or by an Executive Director of the Trust for regulatory or minor amendments.

Subject **Page No**

1 Introduction

1.1 Rationale (Why)

1.1.1 The purpose of this policy is to ensure a structured and systematic approach to the development, review, ratification, implementation and revoking of policies. It sets a framework to ensure that all policies are:

- Of a consistently high standard.
- Produced and presented uniformly.
- Up-to-date and relevant.
- Readily accessible and easily understood by the staff to whom they relate.

1.2 Scope

1.2.1 This Policy will apply to all policies and guidelines produced by Trust staff for use within the Trust and wherever the Trust carries responsibility for the staff it employs, including volunteers, agency, honourees, seconded, students and bank staff.

1.2.2 This Policy replaces all previous Birmingham and Solihull Mental Health NHS Trust policy development and management documents.

1.3 Principles

1.3.1 The Trust Board has a legal responsibility for Trust policy and for ensuring that it is carried out effectively.

1.3.2 All staff should be aware of how policies impact on practice and be able to follow the specified requirements.

1.3.3 Policymaking should be transparent and developed within a process that is understood by all affected.

1.3.4 Policies should also be written to be succinct and easily understood by all staff.

1.3.5 All policies should make clear that the Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this

2 Policy

2.1 Common Format

2.1.1 All policies and guidelines within the Trust will be developed, agreed and implemented in accordance with this policy and in the common format prescribed (see Appendix 2).

2.1.2 Policy writers should ensure that policies can be easily followed and understood by all staff that may have to read them. For this reason policies should be short and written in plain English.

2.1.3 All managers have a responsibility to ensure that all staff are aware of key policies which impact on their roles and should ensure that all staff are able to access any Trust policy, and receive appropriate training and support to ensure that policies can be complied with.

2.1.4 All Policies are required to be approved by a ratifying' committee which will report to the Trust Board, or by an Executive Director of the Trust, for regulatory or minor amendments.

2.2 Exclusions to Policy

2.2.1 This policy will also apply to Clinical Guidelines (appendix 3) though not to other Trust guidance documents and strategies.

2.3 Definition of Terms

2.3.1 For the purpose of clarity the Trust will adopt the following definitions. These should be closely observed in the development of any new guidance document so that the correct term is used and the appropriate route to final ratification is followed.

POLICY	Organisational statement of intent - 'must do' or 'must not do' requirement on all relevant staff.
PROCEDURE ♦	The mandatory steps required ensuring compliance with Frameworks and Guidelines
OPERATIONAL FRAMEWORK♦	Previously referred to as Operational Policies, these sets out the working framework for a specific service. These will be approved by the relevant Executive Director
CLINICAL PROTOCOL	Detailed descriptions of the steps taken to deliver care or treatment to a patient
GUIDELINE ♦	A statement of principles giving guidance but allowing for professional initiative.
CLINICAL GUIDELINE	Systematically developed statements to assist decision-making about appropriate healthcare for specific clinical conditions.
STRATEGY♦	A long-term plan identifying targets over a period and the methods by which these targets are to be achieved.

♦ *managed outside the remit of this policy*

2.3.2 Implementation issues and training needs are an essential element of policy development and are to be identified and addressed before any policy will be ratified (see 3.1.2 below).

3 Procedure

3.1 Development Process for a new policy

3.1.1 Any Trust forum or member of staff may identify the potential need for the development or amendment of a Trust policy. Before proceeding further,

however, the proposal must first be brought to the attention of an appropriate Executive Director whose responsibility it will be either to reject the proposal or to agree it and to appoint a Policy Lead.

3.1.2 Staff developing policies should recognise that they have responsibility to ensure the details included are implemented across all areas of the Trust and to demonstrate that this is happening. It is important that policies are not produced needlessly or produced to transfer responsibilities to other teams.

3.1.3 The Policy lead must inform the Compliance department, who will record the new policy title on the Trust's central database and assign a new policy number within the appropriate category.

3.1.4 Policies must be formulated and developed through any one, or more, Trust forums or committees or a specific working group and may be revisited several times before progressing to the final ratification stage.

3.1.5 All draft policies must include a 'DRAFT' watermark on all pages.

3.2 Policy format

3.2.1 Sections 1 and 2 (Introduction / Scope / Policy) of any policy should be no more than two A4 pages in length, in total.

3.2.2 Policies should be written in plain English for easy readability.

3.2.3 Policy titles should be as brief as possible to facilitate electronic search and so that they are more readily recognisable.

3.2.4 All Policies should be written in the format set out in appendix 2.

3.3 Policy Consultation / Ratification Process

3.3.1 Prior to ratification the proposed policy must be issued on to the Policy Consultation pages of the intranet for a minimum period of at least one month.

3.3.2 The draft policy should also be circulated as a minimum directly to all:

- Executive Directors
- Clinical Directors
- Associate Directors of operations
- Internal Audit and Local Counter Fraud service

3.3.3 It is for the policy lead to identify the appropriate engagement of other groups and committee in consultation with the lead Executive Director.

3.3.4 It is difficult to prescribe the level of consultation required however an assessment should be undertaken on the basis that appropriate staff or others have been given opportunity for involvement and feedback. Ultimately policy implementation is most likely to be successful where staff integral to the policy have been fully involved in the development process. Where a policy has been reviewed and no changes are to be made, there is no need for the policy to go to consultation on Connect

3.3.5 Where specific key responsibilities have been identified within the policy all such staff or relevant managers should be expected to have been involved in the consultation. In particular key issues which should be considered may include:

- Level of involvement of service users / carers and representatives. Should be add a section into the policy template?
- Policies which may impact significantly on a professional staff group or service.
- Involvement of staff side (all HR policies will be reviewed with staff side).

3.3.6 The ratification of the policy must include the Equality Analysis screening form and any subsequent full analysis. Any Equality Analysis forms relating to a policy must be completed in accordance with the Trust's Equality Analysis guidance, which can be found in the Equal Opportunities in Employment Policy. Advice if required is available from HR. The completed Equality Analysis Screening tool must be embedded within the policy as appendix 1 for all policies ratified after 1st April 2017. Where screening identifies the need for a full Equality Analysis, that too must be imbedded in appendix 1

3.3.7 The formulating committee or working group (if an appropriate committee does not exist) must approve the policy in full before final ratification.

3.3.8 Confirmation that the policy is compliant with governance arrangements set out in this policy will be required by the Director of Nursing prior to the ratification of the policy.

3.3.9 Policies that are ratified or rescinded, by an Executive Director, the development and consultation process followed will be the same as that followed for policies approved by Committees.

3.3.10. A policy, implementation plan and equalities impact assessment will be presented for ratification to the relevant committee or Executive Director identified in 3.4.1. Below (see appendix 3)

3.3.11. The ratifying committee or Executive Director in approving the policy will satisfy itself that:

- The requirements of the policy can be met as and when the policy is issued.
- The policy complies with the relevant legal requirements and national guidance, including, for example, NICE and regulation requirements.
- Appropriate consultation has been undertaken.
- Appropriate arrangements are in place for the policy to be met and to be subsequently monitored.

3.3.12. The ratifying committee or Executive Director may agree the policy on the basis of a future implementation date where the implementation plan identifies significant work to be undertaken before necessary arrangements are in place to enable all staff to comply.

3.3.13. Where members of the ratifying committee have significant issues and request changes to the policy this should be referred back to appropriate sub-committee /group rather than agreeing changes.

3.3.14. Formal ratification of a policy will be achieved once the ratifying committee or Executive Director has reported its ratification to Trust Board.

3.3.15. The Trust may sometimes be required to adopt as policy, items which have been produced by other agencies or as part of multi-agency agreements. In such circumstances it may not be possible to present the policy in the Trust format. However, as part of the adoption of the policy by the Trust a two page summary should be produced in line with sections 1 – 2 of the Trust policy format (Policy summary).

3.3.16. All policies should be reviewed in light of the prevention of fraud and corruption. Any policy with possible impacts in these areas must be reviewed by the local Counter Fraud Service, to ensure the policy is fraud proof.

3.3.17. A flowchart describing the consultation and ratification process can be found in appendix 4

3.4 Policy Implementation

3.4.1 Policy leads are responsible and accountable for defining the requirements to ensure that the policy is implemented across all areas of the Trust. Policies should be approved on the basis that the policy lead can demonstrate that compliance can be achieved and not on an assumption of faith.

3.4.2 Any resource requirements of the policy should be addressed as part of the consultation arrangements no policy will be approved if additional resources are required to ensure its implementation and these have not been approved.

3.5 Policy Communication and Distribution

3.5.1 Following notification by the Policy Lead of the ratification of a policy or procedure, the Governance team will update the database and arrange for the final document to be placed on the Intranet under the Policy pages.

3.5.2 It is the responsibility of each Associate Directors and Clinical Directors through their managers to ensure that all staff have access to Trust policies. Where staff have access to the intranet all policies are available. However managers will need to ensure that paper copies are available in areas where staff do not have daily access to the intranet or consider other forms of communication for staff that may not be able read.

3.6 Policy Retention

3.6.1 A master copy of each approved Trust-wide policy will be retained within the Trust by the Associate Director of Governance for a minimum period of 10 years in line with the recommendations contained within 'The Records Management: NHS Code of Practice' (2006).

3.7 Policy Review

3.7.1 The Policy Lead will undertake a full review of any policy or procedure at the end of the first year of implementation, redrafting as necessary and resubmitting for ratification.

3.7.2 At the time of the first re-ratification of any policy it will fall to the ratifying committee or Executive Director to determine the appropriate subsequent review period taking into account operational experience, implementation issues to date and the subject matter. The minimum review period will be one year (unless, exceptionally, it is an interim policy); the maximum period will be three years.

3.7.3 An extraordinary policy or procedure may be created, expedited and ratified on rare occasions when exceptional or emergency situations demand it. In such circumstances ratification will be with the Executive Director. This should be then reported formally to the next meeting of the ratifying committee.

3.7.4 Any full policy review will include a diversity impact assessment to ensure there are no differential and adverse impact on any group of service users or staff, in terms of any of the nine protected categories. Such a review will take into account any changes in legislation or DoH guidance since the policy was last reviewed or ratified.

3.7.5 Minor changes to a policy which do not impact the policy requirement (i.e. Section 2) – e.g. procedural arrangements, may be approved by the responsible committee or Executive Director.

3.7.6 All policies are considered as 'current' until such time as they are revised or re-approved or formally withdrawn. Details of any policies which are over six months past their review date will be reported to the Integrated Quality Committee with details of the reason for delay in their review and anticipated date for agreement.

4 Responsibilities

Post(s)	Responsibilities	Ref
Trust Board	The Trust Board have responsibilities for the ratification of Polices. With the exception of RS 01 Risk Management policy, the Trust Board may choose to delegate its ratification responsibilities.	
Ratifying Committees	Committees with delegated authority to ratify policies will ensure • All policies have an implementation plan • All policies have undergone an equality assessment	
All Staff	Every staff member has an individual responsibility to ensure that they: • Know where to locate policies when necessary i.e. in policy manuals or on the Intranet. • Are familiar with policies or procedures that most affect their daily working practices. • Keep themselves briefed and up to date on policy matters.	
Service, Clinical and Corporate Directors	Ensure that comprehensive arrangements are in place regarding adherence to this policy and how policies and procedures are managed within their own Programme / team in line with the policy. Ensuring that relevant staff are identified to respond to policy consultations. Ensuring that managers can undertake their responsibilities identified below.	
Managers	Ensuring that policies/procedures are followed and understood as appropriate to each staff member's role and function. This information must be given to all new staff on induction.	

	Ensuring that their staff know how and where to access current policies/procedures, whether this is via the Intranet or through hard copy Policy/Procedure Manuals. Ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policies and policy changes.	
Policy Lead (general)	Once identified is responsible for: Drafting (or arranging the drafting) of the policy or procedure following this template. Ensuring all 10 sections of the policy is completed. In the event a section is not relevant, this should be added to the section. Ensuring that the policy complies with any legislation and national guidance/ best practice that may be relevant to the policy or procedure's subject matter. (The rationale for any deviation from best practice must be clearly stated.) Ensuring appropriate consultation and engagement of staff key to the policy implementation. Submitting the policy or procedure to the appropriate forum for agreement and/or ratification. Forwarding the final ratified version of the policy or procedure to the Governance Compliance department for broadcast and dissemination. Organising any implementation or training issues.	
Executive Directors	Executive Directors will be ultimately responsible for policies to which they are the Director lead. They will: • Sanction the development of new policies. • Identify the Policy Lead. • Ensure that appropriate arrangements are in place to ensure that the policy is followed. • Ratify policies that do not have a strategic component, or have requirements of services, within their sphere of responsibility.	
Policy Lead (This policy)	On behalf of the ratifying committees, the Associate Director of Governance is the central control point for administering the distribution of all policies and maintains a database of all Trust policies. This will be undertaken through the Governance team administrator. The Associate Director of Governance will therefore be responsible for: Co-ordinating and managing all Trust-wide policies. Ensuring that a master copy is kept of all Trust-wide policies and procedures for the minimum period of 10 years in line with the guidance set out in 'The Records Management: NHS Code of Practice' (2006). Maintaining a single register of all Trust-wide policies. Ensuring that newly ratified policies follow the prescribed format. Ensuring that policies are kept under review.	

	Being the main authority in all but rare circumstances for the inclusion of new policies or procedures on the Intranet (in the interests of continuity, version control and security). Ensuring that the dedicated Policies & Procedures pages of the Intranet are regularly kept up to date.	
Executive Director (This policy)	The Executive Director of Nursing is ultimately responsible for this policy. Responsible for providing governance sign off for a policy prior to final approval.	

5 Development and Consultation process

Original consultation summary		
Date policy issued for consultation		
Number of versions produced for consultation		
Committees / meetings where policy formally discussed	**Date(s)**	
Executive Directors		
Where received	**Summary of feedback**	**Actions / Response**

6 Reference Documents

Dunning *et al* (1999) Experience Evidence and Everyday Practice, Kings Fund - Field & Lohr 1992 / NICE

7 Bibliography

None.

8 Glossary

RATIFICATION. The formal process of agreeing the contents of a policy, making those contents binding for all Trust employees.

RESCIND. The formal process of revoking an existing policy

9 Audit and Assurance

9.1 The Audit Committee will be responsible for reviewing the effectiveness and implementation of this policy and will review this annually

9.2 The approving committee for any policy will identify how reports will be received on the audit and evaluation of any policy presented for approved. (As defining within the individual policy).

9.3 The monitoring template below lays out the process to be followed, for demonstrating compliance with the key aspects of this policy.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Policies are reviewed within agreed timeframes.	Head of Compliance	Sign off by Director of Nursing	As required	Policy front sheet
Consultation process	Head of Compliance	Sign off by Director of Nursing	As required	Policy front
Ratification process	Head of Compliance	Report to Audit committee	Annual	Audit committee
All ratified policies have been posted on Connect.	Head of Compliance	Report to Audit committee	Annual	Audit committee

10. Appendices

Appendix 1

Equality Analysis Screening Form

Title of Proposal	**Policy development and management Policy**		
Person Completing this proposal	**Hugh McCreedy**	**Role or title**	**Head of Compliance**
Division	**Governance Team**	**Service Area**	**Compliance department**
Date Started		**Date completed**	

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

To provide a structure and process by which all Policies and Guidelines are developed and reviewed in the Trust

Who will benefit from the proposal?

All Staff, service users, stakeholders and visitors

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? Yes **Eliminate discrimination?** It mandates processes that will assist in eliminating discrimination **Eliminate harassment?** It mandates processes that will assist in eliminating harassment **Eliminate victimisation?** It mandates processes that will assist in eliminating victimisation	**Promote good community relations?** It mandates processes that will assist in achieving good community relations **Promote positive attitudes towards disabled people?** Yes **Consider more favourable treatment of disabled people**? It mandates processes that will assist in favourable treatment to disabled people **Promote involvement and consultation?** Yes **Protect and promote human rights?** Yes

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	**0**			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal?				

Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	**0**			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**0**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**0**			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**0**			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	**0**			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**0**			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**0**			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment	**0**			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	**0**			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact is identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				0

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
N/A
How will any impact or planned actions be monitored and reviewed?
N/A
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Through mandating involvement of all in the development and reviewing of policies

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Appendix 2

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

POLICY TITLE

POLICY NO & CATEGORY	**E.g., CG 01**	**E.g., Corporate Governance**
VERSION NO & DATE	**1**	**(Date)**
RATIFYING COMMITTEE or EXECUTIVE DIRECTOR	**Trust Board / Clinical Governance Committee***	
DATE RATIFIED		
NEXT ANTICIPATED REVIEW DATE:		
EXECUTIVE DIRECTOR		
POLICY LEAD		
POLICY AUTHOR *(if different from above)*		
GOVERNANCE APPROVAL		

** delete as appropriate*

POLICY CONTEXT:

- This section should briefly say what the policy is for (a summary of Section 1).

POLICY REQUIREMENT (see Section 2)

- This section should be a copy of Section 2.

Policy Structure:

Title Page - as shown below - consisting of:

- Trust logo
- Title of policy
- Policy number
- Ratifying committee
- Date ratified
- Next review date
- Executive Director
- Policy Lead (& Author if different)
- Policy context)
- Policy requirement

Contents Page consisting of:

- List of headings and page numbers.

1: Introduction consisting of:

- **1.1 Rationale** (why): this states why the policy is necessary and include reference to any relevant guidelines, statutory requirements or other recommendations.
    - This section must include a reference to CNST requirements where a policy relates to this.
- **1.2 Scope (**when, where and who): this defines where the policy will apply, whether a corporate or local procedure supports the implementation of the policy and to whom the policy applies. It also identifies key staff and outlines their responsibilities.
    - Particular attention must be made with regard to Prison Healthcare services. Policy writers should ensure that if there is any reason why the policy may not apply or if variation of the policy is required by the Prison that this is explicitly highlighted.
- **1.3 Principles** (beliefs): this presents the major underlying beliefs on which the policy is based.

  Prescribed text to be included in sec 1.3

  The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this
    -

2: **The policy** consisting of:

- The statement(s) of the standard that is to be achieved (What).

3: The procedure consisting of:

- A step-by step account of how the policy / procedure are to be achieved including a flowchart in all but the simplest cases. (Circumstances may arise requiring variation on how policies are implemented within the Trust's various service areas. A local procedure may be developed in these circumstances).

4: Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All Staff		
Service, Clinical and Corporate Directors		
Policy Lead		
Executive Director		
Others…..		

5: Development and Consultation process consisting of:

- An outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation summary		
Date policy issued for consultation		
Number of versions produced for consultation		
Committees / meetings where policy formally discussed	**Date(s)**	
Where received	**Summary of feedback**	**Actions / Response**

*(*Add rows as necessary)*

6: Reference documents

- A list of documents referred to in the main body of the text. A reference document is any piece of printed material or any other policy and procedure to which the author refers or quotes directly.

7: Bibliography:

- A list of works that the author has used as a source of information evidence or inspiration, but is not referred to directly in the text.
  {Note if there are no documents to list this section should remain but state that there are no documents)

8: Glossary consisting of:

- Definitions of technical or specialised terminology used within the policy.

  {Note if there is no terminology to list, this section should remain but state that there are none)

9: Audit and assurance consisting of:

- What steps will be undertaken to assess how well the policy is working
- What criteria will be used to be assured that the policy is being met.(Completion of the monitoring template)

Element to be monitored	Lead	Tool	Frequency	Reporting Committee

10. Appendices consisting of:

- Additional material that is necessary to the delivery of the policy or procedure, e.g., flowcharts

Appendix 1

Equality Analysis Screening Form

Title of Proposal			
Person Completing this proposal		**Role or title**	
Division		**Service Area**	
Date Started		**Date completed**	
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
Who will benefit from the proposal?			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*		*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*	
Please click in the relevant impact box or leave blank if you feel there is no particular impact.			
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age				
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues				

Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender				
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity				
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity				
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief				
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation				
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being ‘out’ or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment				

This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights				
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
How will any impact or planned actions be monitored and reviewed?				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.				

Full Equality Analysis Form

Title of Proposal			
Person Completing this proposal		**Role or title**	
Division/Department		**Service Area**	
Date Started		**Date completed**	
Looking back at the screening tool, in what areas are there concerns that the proposal treats groups differently, unfairly or disproportionately as a result of their personal protected characteristics?			
Summarise the likely negative impacts		**Summarise the likely positive impact**	
What previous or planned consultation or research on this proposal has taken place with groups from different sections of the community?			
		Please provide list of groups consulted.	**Summary of consultation / research carried out or planned. If already carried out, what does it tell you about the negative impact?**
Group(s) (Community, service user, stakeholders or carers			
Staff Group(s)			
What up-to-date information or data is available about the different groups the proposal may have a negative impact on?			
Are there any gaps in your previous or planned consultations, research or information? If so are there any other experts, groups that could be contacted to get further views or evidence?			

Yes		**No**			
If yes please list below					
As a result of this Full Equality Analysis and consultation, what changes need to be made to the proposal? (You may wish to put this information into an action plan and attach to the proposal)					
Will any negative impact now be:					
Low:		**Legal:**		**Justifiable:**	
Will the changes made ensure that any negative impact is lawful or justifiable?					
Have you established a monitoring system and review process to assess the successful implementation of the proposal? Please explain how this will be done below.					
Action Planning: How could you minimise or remove any negative impact identified even if this is of low significance?					
How will any impact or planned actions be monitored and reviewed?					
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic?					

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Appendix 3

IMPLEMENTATION PLAN for …… (Complete policy title)

Please list the key requirements of the policy and indicate how you will ensure that these are followed by appropriate staff:
For a new policy this should identify all issues which the policy is required to address.

Policy requirement	Issues identified / Action to be taken	Lead Person	Time-Scale

Resources

- **Have the financial impacts of any changes been established?**
- **Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?**

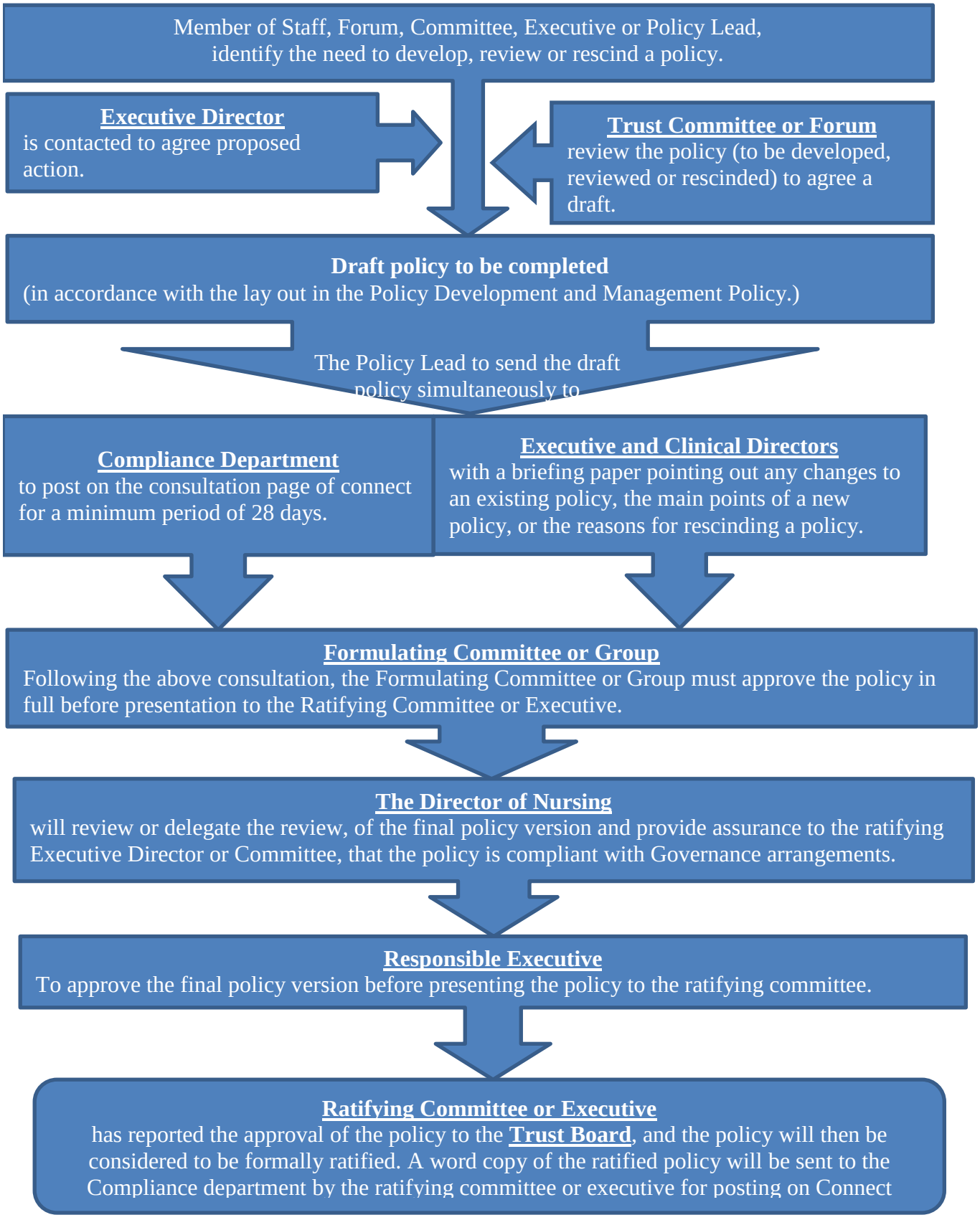
Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues which may arise at a later stage.

IMPLEMENTATION PLAN for …… **(Complete policy title)**

Please list the key requirements of the policy and indicate how you will ensure that these are followed by appropriate staff:
For a new policy this should identify all issues which the policy is required to address.

Policy requirement	**Issues identified / Action to be taken**	**Lead Person**	**Time-Scale**
All policies and procedures within the Trust will be developed, agreed and implemented in accordance with this standard policy and procedure and in this common format (see Appendix 1).			
All managers have a responsibility to ensure that their staff are aware of key policies which impact on their roles and should ensure that all staff are able to access any Trust policy, and receive appropriate training and support to ensure that policies can be complied with.			
All Policies are required to be approved by a senior 'ratifying' committee or Executive Director, which will report to the Trust Board.			
Equality and Diversity • Has an Equality Analysis Screening Form been completed? • As a result of completing an Analysis Screening form, is a full Equality Analysis assessment required. What actions are being taken to reduce or remove disadvantage, where identified?			
Involving service users and carers • Is there a need to provide information to service users and carers regarding this policy? Are there service users, carers, representatives or local organisations who could contribute to the implementation?			
Have the financial impacts of any changes been established?			
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?			

APPENDIX 4. Consultation and Ratification Process



Appendix 5

Clinical Guidelines

Clinical Guidelines recommend how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.

All Trust Clinical Guidelines will be required to be approved by the Trust Clinical Governance Committee.

All guidelines will be presented in a common format which can be readily accessed and understood by staff.

Guidelines will be evidence based and aspire to the development of best practice.

Guidelines will be kept under regular review, subject to clinical audit and updated appropriately.

Development Process

Define area: It is important to clearly define what the guideline is for, when it should be used and by whom.

Literature search: A thorough literature search should be undertaken on the clinical practice relating to the guideline.

Critical appraisal: Critical appraisal of the evidence is essential and should be undertaken by staff suitably trained to do so (training is provided through the library and R&D department). Clinical teams should discuss and review the evidence to inform the production of the guideline.

All Clinical guidelines should be reviewed through the relevant professional forums where they impact on specific professional responsibilities and sent to the professional lead.

Agreement Process

Responsibility for the approval of all clinical guidelines will be with the Clinical Governance committee. In respect of the following areas guidelines will often be developed through the sub groups of the Trust Clinical Governance Committee.

If the introduction of a clinical guideline is linked with the introduction of additional documentation, approval will also be subject to agreement of the documentation through the appropriate forum.

Where the guideline relates to a new intervention or clinical procedure this should be subject to the process set out in the New clinical procedures policy.

Agreement of a clinical guideline should not impact on financial costs unless the financial arrangements to support the implementation of the guideline have been agreed in advance.

Draft guidelines should be published on the intranet for consultation and circulated to all clinical teams normally involved. Where the guideline reflects a common trust wide procedure it may be appropriate to circulate to all clinical directors.

Once agreed all clinical guidelines will be added to the Clinical Guidelines intranet page. Clinical departments will also consider how further how the guidance is disseminated.

Review Process

All guidelines should be formally reviewed every three years.

Guidelines should be kept under continuous review particularly to reflect new evidence and also clinical audit. The mechanism for this should be included within the guideline.

All members of the clinical team are responsible for informing the guideline lead if new evidence is published which may impact on its use.

Clinical audit should be used to review the effectiveness and use of the guideline and should be updated to reflect any findings from the audit.

CLINICAL GUIDELINE

No:	Title

Date of approval	Formulating group

1. Aim of guideline
It is important to identify the aims of the guideline and why it has been developed. This may relate to a particular risk or variation in practice carried out by clinical teams.

2. Developed by
State clearly who has produced the guideline and include a lead person.

3. Who it applies to
State who should be aware of the guideline and in what circumstances/conditions it should be used/not used.

(Clinical teams, staff groups)

4. Guideline
The guideline should be clear and easy to understand.

5. Flow chart
6. Training support / contacts and advice
7. Process for review / feedback
8. Process for audit
9. References
All guidelines should be explicitly referenced. Reference numbers should be identified from the main text to inform how individual steps have been identified.

10. Further information and related guidelines
Sources for further information/background information relating to the guideline including relevant specialist bodies and other related guidelines.

11. Reference to patient information leaflet
It is often good practice to reinforce a guideline with a patient information leaflet particularly for significant/high risk procedures. Therefore list any patient information leaflets which relate to the guideline.