Birmingham and Solihull Mental Health NHS Foundation Trust

POLICY DEVELOPMENT AND MANAGEMENT

Policy No & Category	**CG 01**	**Corporate Governance**
Version No & Date	**14**	**August 2024**
Ratifying Committee	**Trust Clinical Governance Committee**	
Date Ratified	**August 2024**	
Next Anticipated Review Date	**August 2027**	
Executive Director	**Executive Director of Quality and Safety (Chief Nurse)**	
Policy Lead	**Associate Director of Governance**	
Policy Author *(if different from above)*	**Head of Health and Safety and Regulatory Compliance**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT:

- This policy sets out the framework for the development, consultation, 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 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.

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 out 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 this policy and for ensuring that it is effectively implemented.

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 and those that they could have an impact on.

1.3.5 All policies will be divided into 7 broad categories representing subject areas, as follows:

- Clinical
- Corporate
- Human Resources
- Infection Control
- Information Governance
- Mental Health Legislation
- Risk & Safety

1.3.6 All policies will have an adequately completed Equality Impact Assessment that considers the impact of the policy on protected/ specified groups and where any negative impacts are identified these are adequately addressed. Staff will work collaboratively with colleagues from other organisations, to ensure that service users and carers have a positive episode of care whilst in our services.

Information should be shared appropriately in accordance with information governance principles to support this.

1.3.7 All policy leads should determine whether there are any information governance requirements that need to be referenced and included within the policy. For instance, ensuring the correct procedure is followed when sharing confidential or patient information or responding to a request for confidential or patient information. Guidance should be sought from the Information Governance Team: **bsmhft.informationgovernance@ nhs.net**

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 for policy template and appendix 5 for guidelines template.

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 the authorised ratifying committee or by an Executive Director of the Trust, for regulatory or minor amendments.

2.1.5 The Freedom of Information Act (FOIA) 2000 allows individuals to request certain types of information (including policies, guidelines, and standard operating procedures) from public bodies, with the purpose being to ensure there is transparency within the public sector.

Although the default position should be to release information as per the spirit of the FOIA, there are occasions where it is appropriate to apply an exemption and either withhold all or some of the information.

When considering whether a policy, guideline or standard operating procedure should be withheld under the FOIA the author needs to determine if the document contains any commercially sensitive information, any information which if in the public domain may negatively impact the security of Trust systems, or whether any information in the document could negatively impact the health and safety of either our patients or members of staff if it were released into the public domain.

With this in mind, there will be limited occasions where it is appropriate to apply an exemption to the release of either a policy, guideline or standard operating procedure, and you should therefore seek support from the Information Governance Team who will review your document and provide advice as to whether it can be released under the FOIA, and if it is identified that the document should be withheld, provide advice about the most appropriate exemption to apply.

2.2 Exclusions to Policy

2.2.1 This policy will also apply to Clinical Guidelines and other Trust wide guidance (appendix 5) though not to documents such as 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 to ensure compliance with Frameworks and Guidelines.
OPERATIONAL FRAMEWORK♦	Previously referred to as Operational Policies, these set 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.
TRUST WIDE GUIDANCE	Guidance on specific processes that apply to all staff in a consistent way.
APPROVAL	Agreement at the Policy Development and Management Group (PDMG) that a policy or guideline is ready for the final stage, ratification.
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.

♦ *managed outside the remit of this policy*

2.3.2 Implementation plans 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 team, 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 30 days.

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

- Executive Directors
- Clinical Directors
- Associate Directors of Operations
- Specialist committees for the policy as identified by PDMG, for example, Physical Health Committee, MAC, PPAC etc.
- Staff side representatives
- Internal Audit and Local Counter Fraud service (see appendix 6 for a non-exhaustive list of policies which must go to the counter fraud service as part of consultation)

- Staff Network Chairs

3.3.3 One of the aims of PDMG is to ensure that where appropriate, policies are coproduced. Policy leads should therefore consult the relevant service user groups to enable development and consultation as appropriate.

3.3.4 It is difficult to prescribe the level of consultation required however the author should make an assessment on the basis that appropriate staff or others have been given the 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.

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

- Level of involvement of service users / carers and representatives.
- 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 Prior to ratification the policy must pass through the Policy Development Management Group (PDMG) for final approval before it goes to its ratifying committee. The policy author is expected to attend the meeting, present the policy, and answer any questions regarding the policy. PDMG meets monthly.

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 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 Equality Inclusion and Human Rights Policy. Advice if required is available from the Trust's Senior Equality, Diversity, and Inclusion Lead. The completed Equality Analysis Screening tool must be embedded within the policy as Appendix 1 for all policies. Where screening identifies the need for a full Equality Analysis, that too must be imbedded in Appendix 1.

3.3.10 For 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.

3.3.11. A policy, implementation plan and equality impact assessment will be presented for ratification to the relevant committee or to the Executive Director as identified in 3.1.1. Below (see appendix 3)

3.3.12. PDMG or the 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 regulatory requirements.
- Appropriate consultation has been undertaken.

- Appropriate arrangements are in place for the policy to be met and to be subsequently monitored.

3.3.13. PDMG or the Executive Director may agree the policy based on 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.

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

3.3.15. Formal ratification of a policy will be achieved once PDMG makes a recommendation for ratification to the ratifying committee, and this has been agreed there and subsequently at the relevant ratifying committee.

3.3.16. 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).

3.3.17. All policies should be reviewed considering 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. (See appendix 6 for non-exhaustive list of policies)

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

3.3.19 The Risk Management policy follows a different process for ratification as it is owned by the Board and is therefore approved and ratified at a Board session following the agreed review and consultation processes set out in this policy.

3.3.20 There will also be other system wide and multi-agency policies and frameworks that come to PDMG for information and noting only and not for approval.

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 in all relevant areas.

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 Compliance Facilitator will update the database and arrange for the final document to be placed on the Intranet on the Policy pages.

3.5.2 It is the responsibility of each Associate Director and Clinical Director 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 alternative means of access is available in areas where staff do not have routine 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 Code of Practice for Health and Social Care' (2016).

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 considering 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 then be reported formally to the next meeting of the ratifying committee.

3.7.4 Any full policy review will include an equality impact assessment to ensure there are no differential and adverse impacts on any group of service users or staff, in terms of any of the nine protected categories. Such a review will consider any changes in legislation or Department of Health 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 Quality, Patient Experience and Safety Committee with details of the reason for delay in their review and anticipated date for review and sign off.

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.	
Policy Development	To provide assurance to ratifying committees that the policies being presented for ratification, have gone through	

Management Group	the required development, consultation, review and governance arrangements required for ratification. On the basis of the above to recommend the ratification of policies to the relevant ratifying committees and Trust CGC. To report to the Clinical Governance Committee on a quarterly basis, those policies that are past their review date.	
Ratifying Committees	Committees with delegated authority to ratify policies will ensure all policies have passed through and have PDMG approval before ratification.	
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 Leads (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. Attending PDMG to present and answer any queries regarding the policy. 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 duty will be discharged via the Compliance Facilitator. 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 for Quality and Safety (Chief Nurse) 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	04/08/2023	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
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 - **https://archive.kingsfund.org.uk/concern/published_works/000021572?locale=en**

7 Bibliography

None.

8 Glossary

None.

9 Audit and Assurance

9.1 The Integrated Quality 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 H&S and Regulatory Compliance	Central Policy Schedule	Monthly	Policy status reported to PDMG and Trust CGC

Consultation process	Head of H&S and Regulatory Compliance	Sign off by Director of Nursing	As required	Reported to PDMG and Trust CGC
Ratification process	Head of H&S and Regulatory Compliance	Report to Audit committee	Annually	Audit committee
All ratified policies have been posted on Connect.	Compliance Facilitator	Report to Audit committee	Annually	Audit committee

10. Appendices

Appendix 1

Birmingham and Solihull Mental Health NHS Foundation Trust

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**Policy Development and Management Policy**		
Person Completing this proposal	Natassia James	**Role or title**	Head of H&S and Regulatory Compliance
Division	Corporate	**Service Area**	Governance
Date Started	August 2023	**Date completed**	August 2023
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			
Do the proposals affect service users, employees, or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The policy affects everyone positively in ensuring that Trust policies are fit for purpose and accessible to all who need them.			
Do the proposals significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
No			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
No			

Do the proposals relate to an area where there are known inequalities? (e.g., seclusion, accessibility, recruitment & progression)				
No				
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 and include relevant data				
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected

				characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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 in relation to pregnancy and maternity?				
Race or Ethnicity			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on all protected characteristics and ensure that adequate mitigations are in place to address any adverse impacts identified.
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			x	The policy will ensure that the authors of all Trust policies consider the impact of the policies that they are leading on, on human rights and ensure that adequate mitigations are in place to address any adverse impacts identified.
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)				
		No		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				x

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?
Policy authors will need to develop appropriate action plans where concerns have been identified.
How will any impact or planned actions be monitored and reviewed?
Policy authors will need to detail this as part of their policy development or review.
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.
By ensuring compliance with the requirements of this policy.
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 bsmhft.edi.queries@nhs.net. 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

Policy Template
Please note that a word version of the policy template can be found on the policy and procedures page on the trust intranet
http://connect/corporate/governance/Pages/policies-and-procedures.aspx

Birmingham and Solihull Mental Health NHS Foundation Trust

Policy Title

Policy number and category	**E.g., CG 01**	**E.g., Corporate Governance**
Version number and date	**1**	**(Date)**
Ratifying Committee or Executive Director	**Ratifying Committee Name***	
Date ratified		
Next anticipated review		
Executive Director		
Policy Lead		
Policy Author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	***Yes or No**	

** 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.

- List of headings and page numbers.

1: Introduction consisting of:

- **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.
- **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.
- **Principles** (beliefs): this presents the major underlying beliefs on which the policy is based.

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 must be the equality assessment**

Appendix 1 – Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

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?			
Do the proposals affect service users, employees, or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
Do the proposals significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
Do the proposals relate to an area where there are known inequalities? (e.g., seclusion, accessibility, recruitment & progression)			
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 and include relevant data				
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 in relation 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**

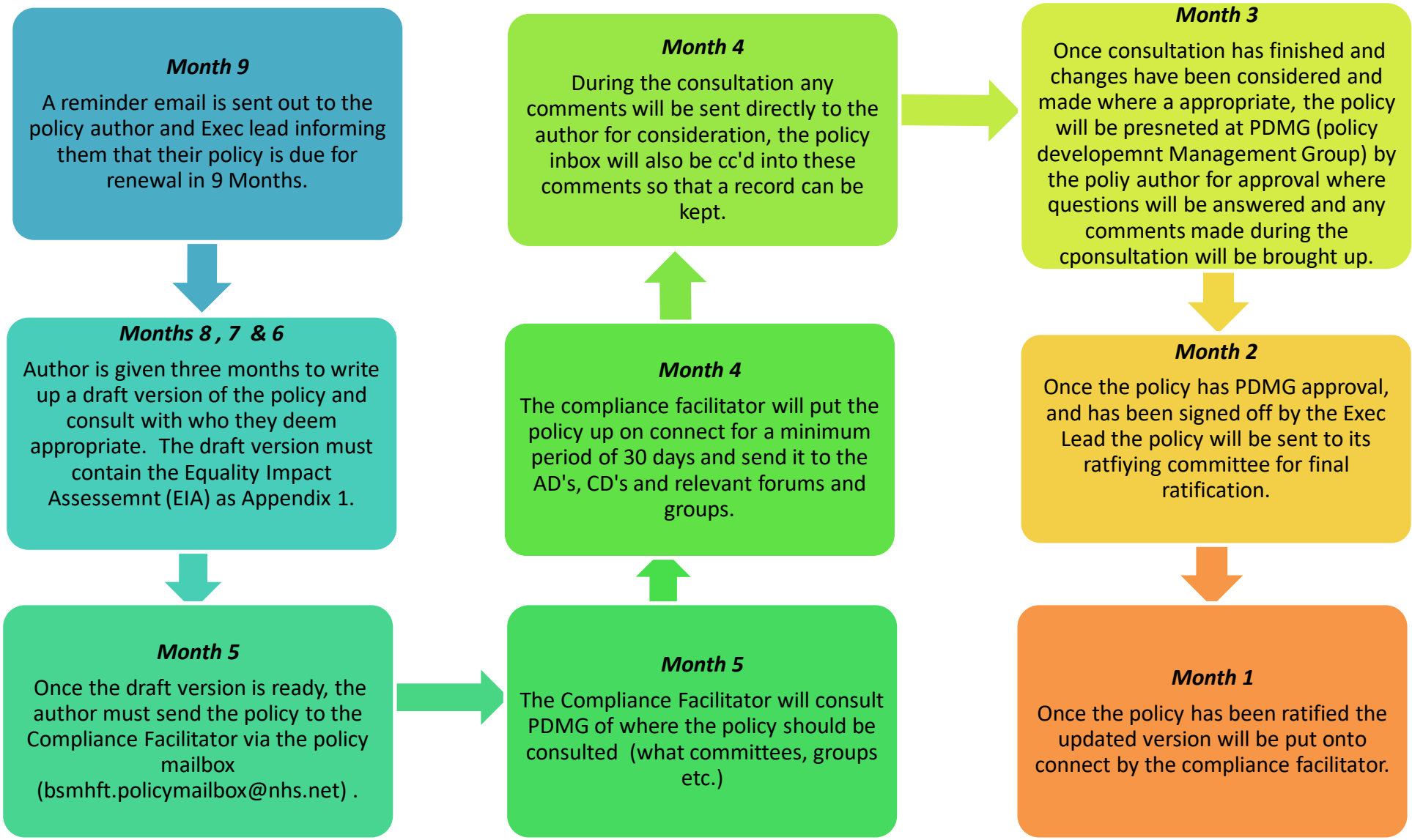
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

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 bsmhft.edi.queries@nhs.net. 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 Template

Policy Section Ref #	**Policy Name** *What is the policy to be implemented?*	**Actions** *What actions must be completed to implement the policy?*	**Responsible** *Who is responsible for the action?*	**Timeframe** *When must the action be completed by?*	**Budget** *How much will it cost to implement the action?*	**Budget Source** *Where will the budget come from?*	**Status** *Is the action- not started, in progress or complete?*

Appendix 4 – Policy Process



Appendix 5 – Guidelines

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 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 (see template below)

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 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 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 Guidelines will be added to the 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.

Guideline Template

Please note that a word version of the guideline template can be found on the guideline page on the trust intranet http://connect/corporate/governance/Clinical-governance/Pages/trust-clinical-guidelines.aspx

Birmingham and Solihull Mental Health NHS Foundation Trust

TRUST GUIDELINE:

Guideline No & Category		*e.g., effective Disorders, Addictions, ADHD etc.
Version No	*Number of versions of the guideline produced	
Formulated Via	E.g. PTC.	
Ratifying Committee	*Trust Clinical Governance Committee	
Date Ratified		
Next Review Date		
Guideline Author		

Guideline Context

- This section should briefly say what the Guideline is for.

Guideline Requirement

- This section should briefly say who the guidelines applies and who doesn't apply to, it should also briefly state what is expected.

Body/Content of the Guideline

Appendix 1 – Equality Impact Assessment

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Appendix 6 – Counter Fraud Service Policies

Consultation with the Local Counter Fraud service must take place for the below policies, please note that this not an exhaustive list.

REF	Policy Name
C49	Patient Property
CG03	Claims / Potential Claims Handling
CG04	Declarations Policy Formerly, Commercial Sponsorships, Gifts & Hospitality
CG06	Complaints
CG12	Use by staff of Mobile Telephones, PDAs and other handheld electronic technology
CG22	Counter Fraud & Anti-Bribery
CG24	Charging Overseas visitors
HR01	Disciplinary Policy
HR03	Management of Sickness Absence
HR04	Special & Carers Leave policy
HR05	Verification & Monitoring of professional registration
HR06	Study Leave Policy
HR08	Maternity Paternity & Adoption Leave policy
HR12	Flexible Working
HR13	Employment Break
HR20	Freedom to Speak up.
HR21	Fitness to practice
HR23	Parental Leave policy
HR26	Recruitment & Selection
HR32	Work Experience
IG01	Confidentiality
IG02	Information, Communication and Technology (ICT)
IG03	Data Quality Policy

IG07	Internet Acceptable Usage policy
RS11	Management of Stress Policy & Guidance
RS14	Police Interventions

MOU or Partnership Document Process Flow Chart