Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
16th December 2010

TITLE	**Policy for Policies**
EXECUTIVE SUMMARY	The Policy for Policies has been reviewed to ensure compliance with NHS LA standards but in particular to provide improved clarity of process and responsibilities. The format is important to achieve compliance with NHS LA but also to ensure staff become familiar with requirements and are able to quickly pick up a policy and understand the requirements. The essential process has not changed.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The policy for policy underpins our approach to policy writing and therefore is a key document to mitigate risk, and assure the Board that the process for development of policy is sound. Approval of this Policy is a matter reserved to the Board
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The Policy has been through consultation with senior managers and views incorporated into the document. It was agreed at TEC on 26th November 2010.
EQUALITY AND DIVERSITY ISSUES	The use of the impact assessment tool has been considered and the use of it is documented in the policy.
LEGAL ISSUES	Policy documents require staff to adhere to a certain way of working and could be produced as a document in court should any staff member be involved in a trial, or any patient make a claim or complaint against the Trust. Hence this overarching Policy is a matter reserved to the Board.
The Trust Board is asked to:	Ratify the revised Policy
Submitted by:	Sarah Johnston , Head of Quality on behalf of Susan Osborne Interim Chief Nurse
Date:	7th December 2010
Decision:	For Approving

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Policies Procedures and Guidelines Review Communication Form

Policy title:	Policy on Policies, Policy, procedures and Guidelines: Writing and Ratification
Consultation start date:	27th October 20010
Deadline for feedback:	10th November 2010
Feedback to be provided to:	Sarah Johnston, Head of Quality

'Before and after' comparison of key changes:

Existing policy	New proposed policy
Responsibilities of staff not clear and poor process being undertaken	Responsibilities of Chairs of Committees and secretaries to committees added, to prevent completed policies reaching committees. Explicit statement that band 8 and above must be policy owners. Policies can be delegated but accountability must be with senior managers
Staff not always being clear around process	More explicit detail in policy around process step by step.
Out of date information relating to employee partnership forum, equality impact assessment and nursing policies	Process updated and made clearer
Procedures undertaken in house	Reference to Marsden Manual as preferred option for documentation of procedure. There is ongoing work to rationalise the current procedures with the Marsden manual which is aimed to be completed by end of year.
Ratifying Committees out of date	Updated ratifying committees. Finance committee now included.
Process unclear for minor amendments being signed off by the Chair of Committee	Reference made to any minor amendments signed off to be noted at following Committee
	Addition of this template to help Committees understand what has changed following feedback form TEC

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Policy on Policies
POLICIES PROCEDURES and GUIDELINES: WRITING and RATIFICATION

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Amendments			
Date	Page	Comments	Approved by
Sep 09	All	Full document review and updated Equality Impact Assessment	Paul Bentley, Acting Chief Executive

Compiled by: Head of Quality & Integrated Governance

Ratified by: Trust Executive Committee

Date:

Date Issued:

Next review date:

Target Audience: All staff

Impact Assessment Carried Out by: Head of Quality & Integrated Governance

Policy Owner: Head of Quality & Integrated Governance

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POLICIES PROCEDURES and GUIDELINES: WRITING and RATIFICATION

See also Committee and Group Policy,
Single Equality Scheme,
Integrated Governance and Risk Management Strategy

1. INTRODUCTION

This documents set out the framework for the creation of Trust wide policies, guidelines and procedures. This includes clinical documents, operational documents and corporate documents. The policy provides the corporate requirements for development of documents, the procedure for ratification, and the requirements after ratification relating to dissemination, implementation, and review. The policy includes requirements set out in the Risk Management Standards by the NHS Litigation Authority and it is expected that staff implement this policy.

2. PURPOSE

This policy is to make clear to staff what is required when policies, procedures and guidelines are created, and how they are approved and ratified.
This policy will ensure that there is a process to ensure all documentation is consistent in format, compilation and dissemination. This policy will ensure that the Trust meets all its legal responsibilities, and that the Trust conforms to risk management standards, thereby ensuring a high level of safety and effectiveness for patients and staff.

3 DEFINITIONS

3.1 POLICY

A policy is a statement of corporate intent. A policy is adopted and followed across the Trust. (It would therefore be very unusual for individual Departments to have their own 'Policies'). Policies direct Trust practice in fulfilling statutory and organisational responsibilities and are contractually and legally binding on all employees.

3.2 PROCEDURE

A procedure is a clinical or operational process or step by step description, which details the manner in which a specified issue is to be handled. This can be described as 'how we do it '.
A procedure should be followed as described. There is no decision making process and no judgement required.

3.2 GUIDELINE

A guideline is a recommendation of practice. It should be based on best practice and must be supported by evidence of expertise. For example: Guidelines for the key worker role in cancer. This is guidance for how the role should operate, based on recommendations from the cancer network, which is a recognised body of expertise. Guidelines are a supportive tool for staff to be able to understand and implement best practice. They are not binding and should be utilised

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within the current operational framework i.e. taking account of other polices and professional codes.

3.4 PROTOCOL

A protocol is a set of guidelines. The term protocol is likely to be used when a set of guidelines is established from multiple agencies and is a recommendation of process or care to be implemented across boundaries.

3.5 DOCUMENT

The term document is taken to mean policies, guidelines and procedures.

3.6 APPROVAL

3.6.1 Approval is the term given to the point where a policy, procedure or guideline has been agreed by a group of experts, or people with operational responsibility for a procedure, to be a completed document.

3.6.2 Approval relates to the content of the policy. For example, the Safeguarding Adults Group will approve the Safeguarding Adults policy. The policy is still required to be presented at a ratifying Committee for the policy to be ratified as a document that the Trust must adhere to.

3.6.3 It is not necessary to obtain official approval for each policy procedure or guideline from a separate Committee or Group as not all documents are clearly linked in this way.

3.6.4 A ratifying Committee can approve and ratify the policy. They will do this by reviewing the ratification form and assuring themselves that the right groups of people have been involved in the document. For example, the consent policy is greatly influenced by law and DH regulations, there is no separate consent committee and this policy will be approved and ratified by Clinical Governance Committee. A range of staff will be invited to input and comment and the CGC will be required to approve and ratify the document.

3.6.5 It is however expected, that where a Committee or Group are clearly linked to a document i.e. the Safeguarding Adult Group, that input and approval of the document will have been sought and identified on the ratification form.

3.6.6 Approval of minor amendments is addressed in 5.8.2

3.7 RATIFICATION

Ratification is the term given to the point where a Committee with delegated responsibility from the Trust Board, will agree that the document is an official Trust document and will be implemented.

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4. RESPONSIBILITIES

4.1 TRUST BOARD

The Trust Board is responsible for the ratification of policies, but will delegate ratification of specific policies as outlined below. An Executive Director must be a member of every ratifying body.

A small number of Policies must always be approved by the Trust Board. These include the Policy on Policies and the Health & Safety policy; see the Reservation of Powers document for the full list.

4.2 QUALITY DEPARTMENT

4.2.1 The Quality department is responsible for the co-ordination of policies procedures and guidelines, ensuring that all required documents have been delivered, and the database and intranet is kept up to date.

4.2.2 The Quality department is responsible for reminding policy owners when a policy becomes due for review, for supporting the policy owners through the process up to ratification and for ensuring that new/revised policies are available on the Intranet. They are not, however, responsible for formatting of policies.

4.2.3 The Quality department is responsible for checking documentation prior to delivery to a ratifying Committee to ensure Committees can operate effectively. The Quality department will check the style and format of the policy ensure there is an explanation of any terms used in the document, that review arrangements are identified, that associated documents are referenced, references and bibliography are evident, and the process for monitoring has been identified. Where gaps are identified these will need to be addressed by the document owner prior to going forward for ratification.

4.2.4 The Quality Department is responsible for ensuring there has been a consultation process, and the ratification process is appropriate. This is achieved by completion of the ratification forms and will be held on file on receipt. Where gaps are identified these will need to be addressed by the document owner prior to going forward for ratification.

4.2.5 The Quality department is responsible for version control and will achieve this by amendment/creation of the footer.

4.2.6 The Quality department are responsible for ensuring that policies are made available on the Trust Intranet; authorisation will be given when all relevant documentation is received to ensure that monitoring of documents can be achieved. The information department will provide a statement for the Aspire global email to inform staff of any new policies, guidelines or procedures.

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4.3 DOCUMENT AUTHORS

4.3.1 Document authors should understand the rationale for the policy, and have confirmation that the policy is required. For example is the policy required for NHS LA risk management standards, is it in response to a safety alert, has it been requested by senior management etc

4.3.2 Policy and guideline owners, and staff setting out a procedure must be a senior member of staff (band 8 and above) have a relevant level of expertise, and hold a position with responsibility for that area. For example the Safeguarding Adults policy is owned by the Head of Nursing with lead responsibility for Safeguarding Adults.

4.3.3 The author is responsible for ensuring the document complies with this policy; the document must be formatted correctly, with evidence of circulation and consultation with stakeholders, and all documentation completed prior to going forward for ratification.

4.3.4 They must ensure that consultation and communication with relevant stakeholders occurs, including service users, to ensure all relevant information is considered. It would be expected that the Safeguarding Adults Group would comment and approve the Safeguarding Adults policy. It would be appropriate and expected that the matrons from the divisions would have opportunity to comment on the policy.

4.3.5 The author is responsible for adding the document to the agenda for the relevant ratifying committee, and must ensure that all paperwork is provided after 4.2.3 is completed.

4.3.6 The document author is responsible for ensuring the ratification form is completed. The purpose of this form is to provide assurance to the ratifying Committee that the process for compiling or reviewing the document is robust. The ratification form provides a guide for document authors to check that they have delivered all requirements. For example the form asks: has the document been adequately circulated, have financial considerations been taken into account etc.

4.3.7 The document author is responsible for completing an impact assessment form and ensuring that any required actions following this are taken forward. Impact assessment is required for policies and guidelines only.

4.3.8 The document owner has responsibility for disseminating information about the document as necessary (in addition to publication on the intranet and information posted on Aspire which will be completed by the information department)

4.3.9 The document owner has responsibility for considering any training implications and to co-ordinate as required.

4.3.10 The document owner has responsibility for considering how policies will be monitored. This can be through an audit process, through monitoring incidents, PALS concerns and complaints, or delivery of good practice. The policy owner must describe this in the policy or guideline.

4.3.11 There is no requirement to monitor procedures however it is best practice to consider auditing compliance with procedures, or audit outcomes, in order to

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provide assurance that practice is followed and patients and staff are safe. For example, infection control procedures are regularly audited for compliance to procedure to assure the organisation that good practice is consistent.

4.3.12 The document owner is responsible for ensuring the policy is kept up to date.

4.4 CHAIRS OF RATIFYING COMMITTEES

4.4.1 The Chairs of Committees have responsibility for approving minor amendments to an existing policy if required. Changes considered to be of a minor nature are updating job titles or job functions, telephone numbers etc. All occasions of chairman's action must be reported to the next meeting of the Committee/Group and recorded formally in the minutes.

4.4.2 The Chairs of Committees have a responsibility to direct Committee members to an indication of whether the policy is ratified, or whether additional amendments or information is required. Chairs should advise members that content is not necessarily required to be reviewed in detail but Committee members should be assuring themselves that the policy has been compiled or reviewed by the relevant staff and due process has been followed.

4.5 SECRETARIES TO THE RATIFYING COMMITTEES

4.5.1 The secretary to the Committee is responsible for ensuring the policy is accompanied by the relevant documentation. In particular the ratification form must be provided to Committee members to enable them to understand what the policy is for, and to assure themselves that the document has been compiled appropriately with the relevant expertise. The ratification form enables members with no expertise in the document content to effectively contribute to the ratification process.

4.5.2 The secretary to the Committee is required to inform the policy owner and the Quality department of the outcome of a document being presented for ratification.

4.6 DIRECTORS, CLINICAL DIRECTORS AND DIVISIONAL MANAGERS

Directors, Clinical Directors and Divisional Managers are responsible for ensuring that staff are made aware of policies, and receive specific training or instruction if appropriate.

5. HOW TO CREATE/REVIEW POLICIES PROCEEDURES AND GUIDELINES, COMPLETE THE RATIFICATION PROCESS, AND ENSURE THE DOCUMENT IS AVAILABLE TO STAFF

Appendix 1 is a flow chart which demonstrates the process for creation or review of a document, the ratification process and what is required after ratification to ensure the document is available on the intranet for staff.

It is important to understand this process. It will ensure that the document owner completes all responsibilities, enables other staff to pick up responsibility at the right points, and enables the Quality department to co-ordinate the process.

5.1 INFORMATION FOR WRITING

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Policies procedures and guidelines must:

- be related to a single topic, clearly identified by the title
- be clearly written, and unambiguous
- be based on the most recent information available and should reflect best practice
- clearly indicate relevant legislation or directives
- be cross-referenced as appropriate
- be formulated by key staff involved in the relevant work practices or requirements
- be circulated widely to interested parties for comment
- show the date of ratification, the ratifying body, the review frequency and a contact for comments
- note who has carried out the impact assessment
- record who the target audience is

5.2 CREATING PROCEDURES

A procedure is best viewed as a step by step process (see Marsden manual set up) or as a flow chart. This helps staff easily follow the requirements. A procedure document must be accompanied by a ratification form when being received by Committee but does not follow a template. Consideration should be given as to whether a competency is required.

5.3 MARSDEN MANUAL

The Trust utilises the Marsden Manual for nursing procedures, which is reviewed automatically and independently of the Trust. Wherever possible the Marsden Manual procedures should be utilised.

5.4 NHS LA RISK MANAGEMENT STANDARDS

The NHS LA risk management standards set out the criteria for the content requirements for a number of policies relating to risk. If you are a policy owner for risk management standards it is essential that you refer to the latest NHS LA guidance for acute Trusts to ensure all the minimum requirements are incorporated into the policy.

http://www.nhsla.com/riskmanagement

5.4.1 Review arrangements: a full review must be undertaken as a minimum every three years. Where new guidance or regulation is issued the policy should be amended to reflect this.

5.5 TEMPLATE FOR POLICIES AND GUIDELINES

Appendix 2 is the template staff must use to create a policy or guidance document.

The front sheet should be completed in draft and finalised after ratification of the document.

Review dates can be up to 3 years from the ratification date.

Reference should be made to other documents that link to the policy.

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The template includes mandatory headings which are required to comply with NHS LA risk management standards. Further headings can be added if necessary.

The required headings are as follows

5.5.1 Introduction

5.5.2 Purpose

5.5.3 Duties/Responsibilities

5.5.4 Dissemination and Implementation: the method of communicating the document to staff should be stated. The Quality department will ensure the document is placed on the intranet and information will be placed on Aspire global email. Consideration must be given to any additional specific communication that may be required to ensure relevant staff are aware of the document. Any training needs to enable the document to be implemented need to be stated.

5.5.5 Process for monitoring compliance with the effectiveness of the policy: the method of monitoring should be stated; this could be audit, survey, review, questionnaire etc. In this section it should be stated who will undertake monitoring, which method will be used and how often it will occur. In addition, where there are gaps in practice, there should be information on how changes will be implemented, how lessons learned will be shared, and at which groups this will take place.

5.5.6 Equality Impact Assessment

5.5.7 Archiving Arrangements: select one of the options provided in the template depending on whether the document is Trust wide or local

5.5.8 References and/or Bibliography

5.5.9 Appendices should follow at the end of the document. This must include the Equality Impact Assessment

5.6 STYLE AND FORMAT OF POLICY

5.5.1 The corporate font is Arial and font size is 11.

5.5.2 Paper margins must be 2cm all around.

5.5.3 Main headings should be in CAPITAL LETTERS and **bold**.

5.5.4 Subheadings should be in CAPITAL LETTERS and underlined.

5.7 EQUALITY IMPACT ASSESSMENT

Appendix 3 is the Equality Impact Assessment

5.6.1 All public bodies have a statutory duty to carry out Equality Impact Assessments. Equality Impact Assessments are a systematic way of ensuring that legal obligations are met in relation to both service provision and employment and should

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facilitate the identification of any potential inequalities or discriminatory elements resulting from policy, strategy or practice.

5.6.2 Equality Impact Assessments provide the framework to assess and consult on how policies, guidelines or procedures impact on equal access and inclusion.

5.6.3 The Trust has produced a Single Equality Scheme which is concerned with Race, Disability, Gender, Age, Religion or Belief and Sexual Orientation. The link below will access this

http://www.ashfordstpeters.org.uk/attachments/1345_Single%20Integrated%20Equality%20Scheme.pdf

5.6.4 All policies need to have an equality impact assessment, which should identify whether a more detailed impact assessment or any action is required. This document must be published in the policy as an appendix.

5.6.5 Acting on the Impact Assessment: where an action is identified this can be discussed with the Equality and Diversity Steering Group who can support the policy owner to understand what is required and give direction as to what may be required

5.6.6 Example of a positive impact assessment: an impact assessment on a policy relating to pain control and the use of patient controlled devices post operatively identifies an issue for patients that do not speak English. Information is given to patients in the recovery area on how to use the pumps and if patients cannot understand how to operate the devices they cannot use his form of pain control. This is not provision of equitable care and is unacceptable. The policy needs to make provision for ALL patients to have equitable choice and a new way of informing patients about their choices needs to be established.

5.8 CONSULTATION PROCESS

Appendix 4 is the Policies, guidelines and procedures review communication form

5.8.1 It is important that the document is circulated to a wider audience for comments prior to ratification. This enables staff will be implementing the document, or be affected by the document to feed into the process. The audience should include a representative group of those staff that will be expected to use the policy and the holder of any named roles relevant to the policy.

A reasonable period should be allowed taking into account the prioritisation of the document, availability of key people, and responses received.

5.8.2 When a document is being reviewed you will need to help staff understand what changes are being made. Appendix 4 provides a form to do this.

5.8.3 The document should be placed on the Tdrive under ‘Policies for Consultation’ with the Policies, Guidelines and Procedures Review Communication Form, to enable all staff to access this.

5.8.4 All employment policies are received by the Employee Partnership Forum for consultation on the development and implementation of employment policies. For

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policies that pertain solely to medical & dental staff these are presented to the Joint Local Negotiating Committee for consultation.

5.9 RATIFICATION

Appendix 5 is the ratification form

5.9.1 The ratification form provides the ratifying Committee with the necessary information to enable members to ratify the document. It must be fully completed and sent to the Committee secretary as part of the paperwork.

5.9.2 Where minor amendments are required e.g. change of names, job titles, these can be made and approved and ratified by the relevant Chair of the Committee through Chairman's action. The review form at Appendix 4 should be used to clearly document the changes. The amendments must be recorded in brief on the front sheet of the document for policies, guidelines and procedures.

5.9.3 Committees responsible for ratifying documents:

Document Type	**Ratifying Committee**
Corporate, and governance policies	Trust Executive Committee (TEC) Integrated Governance Assurance Committee Trust Board
Financial Policies	Finance Committee
Workforce policies	TEC
Nursing and Midwifery policies	Nursing and Midwifery Committee
Policies related to clinical quality	Clinical Governance committee
Policies relating to safety and risk	Safety & Risk Committee
Policies relating to drugs	Drugs and Therapeutics Committee
Health and Safety policies	Health and Safety Committee

5.9.4 The directorate pharmacist must be consulted in respect of any policy comprising an aspect of drug prescribing/administration/management. The policy must also be presented at Drugs & Therapeutics Committee. This committee can either ratify the policy, if it relates solely to drugs, or approve the content prior to presentation at a more senior committee for ratification.

5.9.5 The policy owner should nominate a Committee member to present the policy. This is usually the relevant executive or the secretary to the Committee. In some case you may need to present your policy if it requires detailed or expert explanation. In most cases the ratification form and the review communication form should provide the relevant information for the Committee.

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5.9.6 For documents to be presented to Trust Board and TEC a Committee front sheet will be required. Please refer to Committee and Group Policy or the Head of Corporate Affairs for further information.

5.9.7 Appendix 4 should be supplied to help the Committee understand the key changes.

5.10 AFTER RATIFCATION OF A DOCUMENT

5.10.1 The secretary of the group will inform the document owner when the document has been ratified and if any amendments or actions have been requested.

5.10.2 The front sheet needs to be completed. Policies will need to be reviewed when statutory requirements/best practice guidelines dictate, or no longer than 3 years after the previous review/initial ratification.

5.10.3 Once completed the document owner should forward the document with ratification form and impact assessment to the Quality department. An email receipt will be provided which you should keep.

5.10.4 The Quality department are responsible for ensuring the document is archived and sent to the information department for inclusion on the intranet.

5.10.5 The information department will provide a statement for the Aspire global email to inform staff of any new policies, guidelines or procedures. The owner of the policy should provide Simon Leathers in the information department relevant information to be communicated.

5.11 CONTROL OF DOCUMENTS AND ARCHIVING ARRANGEMENTS

5.11.1 Ratified documents should be sent to the Quality department for final checking, and to upload onto the intranet via IT. The documents will be organised into volumes on the intranet with clear dates for review. These will be marked green if in date, amber 3 months prior to review date, and red if expired

5.11.2 Responsibility for archiving trust-wide policies lies with the Quality Department. Electronic folders are set up to hold master copies

5.11.3 Requests for retrieval of documents can be made to the Quality Dept.

6. DISSEMINATION AND IMPLEMENTATION OF THIS POLICY

The policy will be disseminated through the Aspire global email.
The policy will be circulated to Chairs and secretaries of ratifying Committees, and support given to ensure implementation.
Policy training days are set up at intervals to support staff.

7. MONITORING OF THIS POLICY

The Quality department will, on receipt of every corporate policy, will ensure that it meets the requirements as set out in this policy. This will be achieved by the checking documentation for completeness including the policy itself, and the ratification for. Where gaps are identified the document owner will be required to address this.

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Any risk identified will be highlighted as appropriate and considered for the risk register by the Clinical Risk Manager.

Risk related to policies will also be linked to compliance with essential standards and NHS LA. These will be highlighted by the Clinical Risk Manager and the Head of Quality and Governance and fed back to the relevant standard owners to be considered in compliance reports.

8. EQUALITY IMPACT ASSESSMENT FOR THIS DOCUMENT

This can be found in Appendix 3.

9. ARCHIVING OF THIS POLICY

This is a Trust-wide document and archiving arrangements are managed by Quality Dept. who can be contacted to request master/archived copies.

10. REFERENCES AND BIBLIOGRAPHY FOR THIS POLICY

NHS LA Risk Management Standards for Acute trusts, PCT's and Independent Sector Providers of NHS Care - 2010/2011, NHS Litigation Authority

Essential Standards of Quality and Safety, Care Quality Commission, March 2010

Compliance Framework, Monitor, March 2010

Reservation of Powers Document, Standing Orders 2010, Trust net

11. APPENDICES

Appendix 1 Flow chart for process for Policies, Guidelines and Procedures

Appendix 2 Template

Appendix 3 Equality Impact Assessment

Appendix 4 Policies, guidelines and procedures review communication form

Appendix 5 Ratification form

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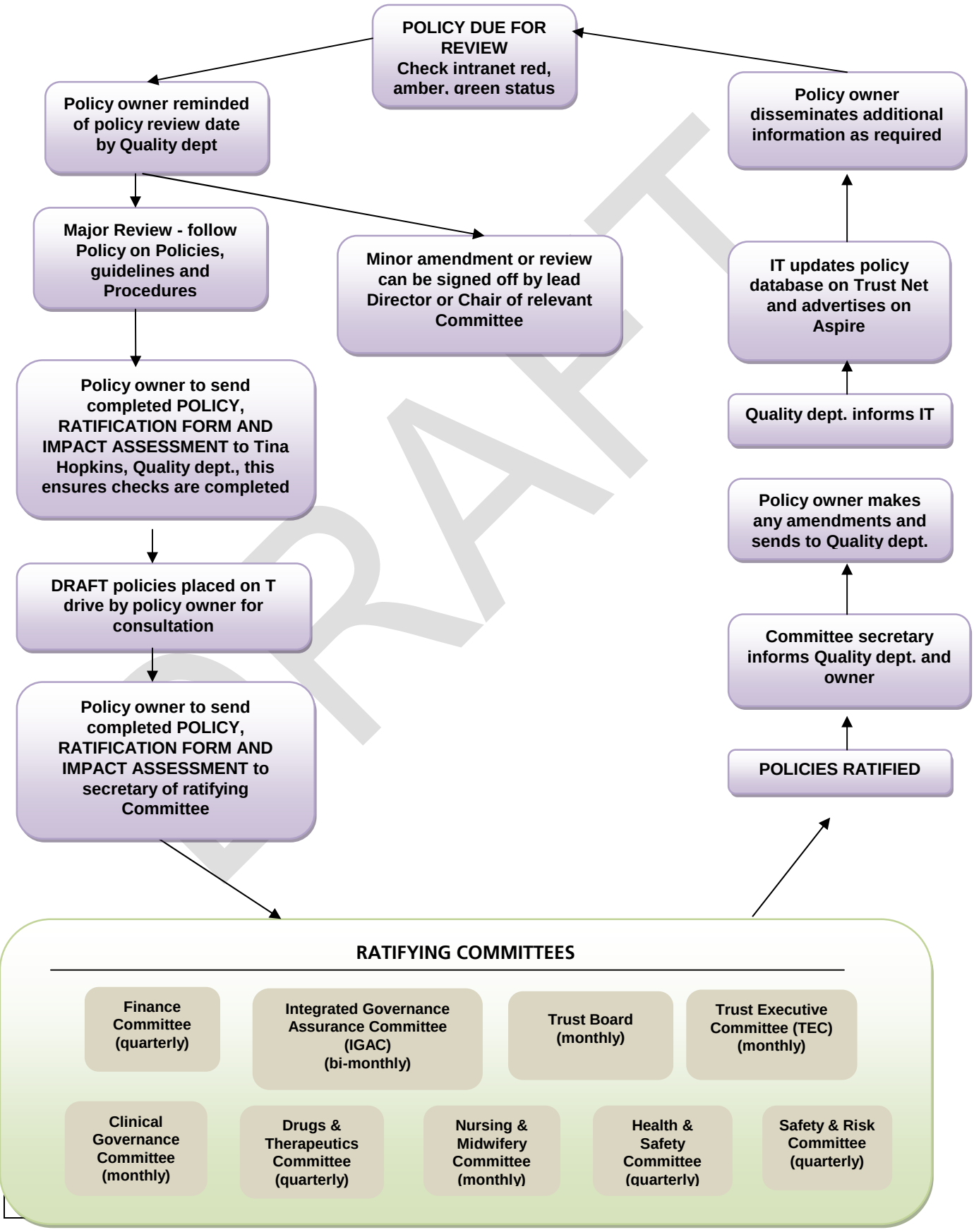
APPENDIX 1

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

FLOW DIAGRAM FOR POLICY RATIFICATION



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APPENDIX 2

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Note: Guidance comments are written in *italics*

POLICY/GUIDELINES NAME

Amendments			
Date	Page(s)	Comments	Approved by

Compiled by:

In Consultation with: *This could be named individuals or a particular group/committee*

Ratified by:

Date Ratified:

Date Issued:

Review Date: *Usually a maximum of 3 years*

Target Audience: *e.g. All staff / All nursing staff / All Non-clinical staff / All Clinical Staff / All administrative staff*

Impact Assessment Carried Out By:

Comments on this document to:

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ASHFORD & ST. PETER'S HOSPITAL NHS FOUNDATION TRUST

POLICY/GUIDELINES NAME

See also: *Reference to any other pertinent policies/procedures/guidelines*

Corporate font is Arial and font size is 11. Paper margins must be 2cm all round.

Main headings should be in CAPITAL LETTERS and ***bold.***

Sub heading should be in CAPITAL LETTERS AND underlined.

1. **INTRODUCTION**

2. **PURPOSE**

3. **DUTIES/RESPONSIBILITIES**

4. **DISSEMINATION AND IMPLEMENTATION**

5. **MONITORING OF COMPLIANCE**

6. **EQUALITY IMPACT ASSESSMENT**
   An Equality Impact Assessment must be carried out for every policy document, referenced in the main body of the document and included as an appendix.

7. **ARCHIVING ARRANGEMENTS**

   Please select from the following:

   This is a Trust-wide document and archiving arrangements are managed by the Quality Department, who can be contacted to request master/archived copies.

   Or

   Explain how the document archiving system works in the area to which this document relates.

8. **REFERENCES AND BIBLIOGRAPHY**

9. **APPENDICES**

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Equality Impact Assessment Summary

Name:

Policy/Service:

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)

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Key Findings

- Describe the results of the assessment
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

Conclusion

- Provide a summary of the overall conclusions

Recommendations

- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

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Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

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APPENDIX 4

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Policies Procedures and Guidelines Review Communication Form

Policy title:	
Consultation start date:	
Deadline for feedback:	
Feedback to be provided to:	

'Before and after' comparison of key changes:

Existing policy	New proposed policy

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APPENDIX 5

PROFORMA FOR RATIFICATION OF POLICIES PROCEDURES and GUIDELINES BY RATIFYING COMMITTEE

- Please complete this form electronically
- Include contact telephone numbers
- The boxes will expand as required

Policy/Guidelines Name:	
Name of Person completing form:	
Date:	

Author(s) *(Principle contact)*	
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	
Date of final draft	
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? *(delete as necessary)*	Yes No
By whom:	
Is this a new or revised policy/guideline? *(delete as necessary)*	New Revised
Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*	
Who is the policy/guideline primarily for?	
Is this policy/guideline relevant across the Trust or in limited areas?	
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?	
Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*	
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?	
Has the policy been checked against minimum requirements for NHS LA Standards (if applicable)	
What (other) information sources have been used to produce this policy/guideline?	
Has the policy/guideline been impact assessed with regard to disability, race,	

gender, age, religion, sexual orientation?	
Other than the authors, which other groups or individuals have been given a draft for comment?*(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*	
Which groups or individuals submitted written or verbal comments on earlier drafts?	
Who considered those comments and to what extent have they been incorporated into the final draft?	
Have financial implications been considered?	
Proposed review date	

DRAFT

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Equality Impact Assessment Summary

Name: Sarah Johnston, Head of Quality

Policy/Service: Policy for Policies, Policy, procedure, and guidelines: writing and ratification

Background

- Description of the aims of the policy
- Context in which the policy operates
- Who was involved in the Equality Impact Assessment

The aim of the policy is to set u out the process for developing policies, procedures and guidance, and the process for approval and ratification of the document. The policy aims to ensure a robust standardised process which facilitates high quality effective polices which can be clearly understood by staff and therefore support adequate implementation.

The Impact assessment has been completed by Sarah Johnston with some advice form E&D programme lead

Methodology

- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)
- The data sources and any other information used
- The consultation that was carried out (who, why and how?)

The policy itself does not impact on race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age however it ensures that impact assessments are required for all policies and guidelines. The policy ensures that policy owners must demonstrate an impact assessment for all polices to the relevant ratifying Committee.

Previous impact assessments carried on policies have indicated needs that would have been missed if this process had not been in place. Particular issues are language barriers and the need to ensure equity and choice of care options.

A full consultation has not been required.

Key Findings

- Describe the results of the assessment
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

There are no adverse impacts identified from this assessment.

Conclusion

- Provide a summary of the overall conclusions

The policy for policies provides a mechanism whereby the Trust should be assured that impact assessments are carried out on all policies and guidelines. A process is in place for the Quality

department and ratifying Committees to ensure this has taken place, and also to view the impact assessment and consider whether this is adequate, and request any amendments or additions as appropriate.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified Describe the plans for reviewing the assessment
Impact assessments and the actions indicated from these assessments will be reviewed at the annual review and consideration will be given to whether the process is adequate.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)