Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY ON THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF POLICIES

Policy author	Trust Secretary
Accountable Executive Lead	Director of Governance
Approving body	Trust Management Board
Policy reference	SWBH/ORG/011

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – Policy Authors
2 – Equality and Diversity Team

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1 – All other staff

POLICY APPROVAL DATE:
September 2011

POLICY IMPLEMENTATION DATE:
November 2011

DATE POLICY TO BE REVIEWED:
September 2014

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
2	April 2007	April 2007	April 2009	
3	August 2009	August 2009	August 2011	Amended to include new profile, responsibilities of Trust Secretary and Head of Equality and Diversity and strengthen the requirements for EIA
4	January 2011	January 2011	August 2011	Minor amendments to include reference to Trust Staff Policy Handbook and clarification of process around use of Accountable Lead discretionary authority. New EIA toolkit included.
5	September 2011	October 2011	September 2014	Major rewrite, including incorporation of feedback form the NHSLA assessment in February 2011, inclusion of a key points section, guidance on length and new cover submission proforma

POLICY FOR THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF POLICIES

KEY POINTS

1. Wherever possible, policies should be no more than **ten sides** of A4 in length (excluding front sheet, document history and appendices).

2. They should have an identified Policy Author and Accountable Executive Director clearly identified on the front page.

3. Each policy should identify a list of groups of staff to whom the policy is most applicable

4. A ‘Key Points’ section (a maximum of **one side** of A4) should be included, outlining the most significant elements contained in the policy. It must be emphasised within the policy that this list is designed to be a quick reference guide and should not be read in isolation of the full policy.

5. New and revised policies should be subjected to an initial equality impact assessment and, where necessary, a full equality impact assessment.

6. All comprehensive implementation plan must be developed for all policies.

7. All policies will contain an ‘Auditable Standards/Monitoring Effectiveness’ section that will outline the system to be used to monitor compliance.

8. All policies should contain a flowchart or process map showing the key steps within the policy.

9. New policies are to be formally reviewed after **three years** unless there is a specific requirement to review more frequently.

10. Consultation with groups of staff, service users or external bodies that may be affected by the introduction of the policy is expected before the policy is submitted for approval by the appropriate Executive Board. A minimum period of **three months** consultation is required for new or significantly revised policies.

11. The most critical key points of or changes to new and revised policies will be communicated to all staff via the daily e-mail communications bulletin and the monthly ‘Hot Topics’ briefing after their approval.

12. An electronic copy of approved and obsolete policies will be retained centrally.

13. Policy Authors will be reminded of the need to review a policy **six months** prior to the review date.

14. Copies of all policies will be available on Trust’s intranet.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

POLICY FOR THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF POLICIES

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POLICY ON THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF POLICIES

1. INTRODUCTION

1.1 This document is designed to ensure a structured and systematic approach to the development, approval and management of Trust-wide policies. It establishes a framework to ensure that all Trust-wide policies are of a consistently high standard, are up to date and that staff have access to and implement them correctly. The policy also describes the format in which all new polices must be developed and produced, a series of principles that should be applied and a procedure to be followed.

1.2 This document relates to Trust-wide policies, defined as those impacting on the majority of staff within the Trust. Policies developed at and relevant to divisional, directorate or service level are expected to follow the same format detailed in this document, yet do not need to be presented to the Executive Boards for approval. Local arrangements must be made to develop, approve and manage policies in a manner consistent with that for Trust-wide policies. They must be wholly consistent with corporate policies if they address the same or related subject matter.

1.3 Procedures, protocols, guidelines and standards set out a process for enabling staff to comply with a policy. As the various terms are open to different interpretation, the definitions adopted for the purpose of this document are set out in Section 3 below.

2 OTHER POLICIES TO WHICH THIS POLICY RELATES

2.1 The development, format and dissemination of locally produced/adapted clinical guidelines is covered by a separate Trust-wide document entitled ‘Clinical Guideline Development Policy’ (Clin/043).

2.2 If, as part of the Auditable Standards/Monitoring Effectiveness requirements a clinical audit is planned, the ‘Policy for Undertaking a Clinical Audit’ (Org/103) should be followed.

2.2 It relates to all other policies developed within the Trust as the guide for development, approval and management.

3. GLOSSARY AND DEFINITIONS

3.1 A **policy** is a written statement of intent, describing the broad approach or course of action the Trust is taking with a particular issue. Each policy must include specific steps (procedure) as to how it is to be accomplished. A policy enables management and staff to make correct decisions and deal effectively and comply with relevant legislation, Trust rules and good working practice. Once approved, policies are mandatory for all staff.

3.2 A **procedure** is a documented series of related steps designed to accomplish a specific task in a specified chronological order. The procedure will accomplish the goals and directives of a related policy. Procedures included within a policy are mandatory for all staff.

3.3 **Guidelines** are tools designed to close gaps between current practice (and the outcomes associated with current practice) and other alternative practices (and the outcomes associated with those practices). Guidelines are decision tools to help staff make informed decisions by making clear the benefits, harms and costs of different options.

3.4 **Protocols** are formal sets of procedures to follow in order to achieve a specific course or outcome, specifically agreed for designated staff. A protocol sets out a precise sequence of activities to be adhered to.

3.5 **Standards** are statements specifying a required level of performance for the purpose of monitoring or auditing

4. POLICY DEVELOPMENT PRINCIPLES

Policies must be developed in accordance with the following principles:

4.1 Any of the following can prompt the development of a new policy or the review of a current policy:

- Guidance from external organisations
- Changes in legislation
- New areas of professional practice
- Changes in joint working arrangements
- Points of learning from a complaint, serious incident or other governance investigation
- Need for change identified in another related policy
- Planned policy review cycle
- Feedback from users, carers, staff, etc

Please note, this is not an exhaustive list.

4.2 The front page of all policies must follow a standardised approach (see Appendix C).

4.3 Policies will be developed in accordance with the procedure outlined in Section 6 to ensure both that the governance arrangements are adequate and a standard structure and format is applied to enable a consistency in presentation.

4.4 Policies should, where possible, be no more than ten sides long (excluding submission proforma, front sheets, history log and appendices). Appendices should also be concise and as few in number as possible and must be referenced within the body of the policy. Approving groups / committees must be satisfied that policies longer than this are justified.

4.5 Policies will identify a list of groups of staff to whom they apply most essentially.

4.6 Policies will contain a 'key points' section at the front, on a maximum of one page, stating its most significant elements.

4.7 All policies, where possible, will contain a flowchart or process map, detailing the key steps that staff are required to follow in the policy, as an appendix.

4.8 An Auditable Standards/Monitoring Effectiveness section must be included to identify the way(s) in which any assessment of compliance with the policy will be undertaken. This must be determined by the Policy Author, taking into account achievability and the resources needed to undertake such auditing / monitoring. In the case where auditing is required, then the frequency of the audit must be stipulated. If a clinical audit is required to measure compliance with processes then see section 6.0.

4.9 Policies will be developed with appropriate internal and external consultation.

4.10 Policies will be reviewed by the policy author annually and be subject to a formal review and approval every three years.

4.11 All policies must be subject to an initial equality impact assessment and a full equality impact assessment if directed by the initial assessment. The submission proforma (Appendix B) should indicate that the policy has been subject to this process and has been signed off by the Head of Equality and Diversity.

4.12 An implementation plan to introduce and embed the requirements of the policy into the organisation will be developed. Actions forming the implementation plan, together with their relevant timescales for completion, should be discussed with and agreed by the relevant managers, clinicians and staff with responsibility for delivering the actions, prior to the implementation plan being presented with the policy for approval.

4.13 A copy of all Trust policies will be held centrally and will be accessible through the Trust's intranet. A separate archive of current and former versions of the policies will be retained by the Trust Policy Co-ordinator.

5 ROLES AND RESPONSIBILITIES

5.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

5.2 Trust Board

a) The Trust Board is responsible for setting the strategic context in which organisational policies are developed.

b) The Trust Board is responsible for the formal review and approval of those policies presented at the discretion of the Accountable Executive Lead, including those which external agencies require to have Board approval.

c) The Trust Board has delegated powers of policy approval to the Chief Executive, who has chosen to discharge this duty through the following Executive Boards:

- The Trust Management Board
- The Governance Board

5.3 Director of Governance

Oversight and accountability for ensuring that effective arrangements are in place for the development, approval and management of policies.

5.4 Trust Secretary

The Trust Secretary has responsibility for ensuring that effective processes are in place for development, approval and management of policies.

The Trust Secretary will undertake to check that all appropriate documentation is completed adequately and confirming that necessary consultation has been undertaken prior to the policy being presented for approval.

The Trust Secretary will work with the Trust Policy Co-ordinator to ensure that policies are lodged on the Trust intranet and are communicated effectively to the Trust when approved.

5.5 Trust Policy Co-ordinator

a) Ensure that an electronic database of policies is maintained and that documents are readily accessible to all relevant staff.
b) Initiate the scheduled review of policies by informing the author of the need six months prior to the review date.
c) Ensure appropriate systems for dissemination of agreed policies, including within the daily internal staff news issued by the communications department and the 'Hot Topics' briefing programme.
d) Administer the approval process in line with this policy.
e) Ensure policies are posted on the Trust's intranet and internet, as appropriate.
f) Maintain accurate records of approval.
g) Maintain an accurate archive of the previous versions of any revised or reviewed policy.
h) Seek confirmation that all elements of the implementation plan have been completed once the final date in the plan is reached.
i) Complete the relevant sections of the Key Indicators Checklist proforma (Appendix G) prior to and after approval of the policy.

5.6 Head of Equality and Diversity

The Head of Equality and Diversity will:

a) review policy equality impact assessments undertaken to confirm that appropriate consideration has been given to potential equality and diversity issues prior to policies being submitted to the relevant approving bodies for approval.
b) maintain a central database of all equality impact assessments.

5.7 Accountable Executive Leads

Executive Directors (referred to as the 'Accountable Executive Leads' hereafter) are responsible for overseeing effective implementation of policies relevant to their areas of responsibility. Draft policies are to be reviewed by the relevant Accountable Executive Leads, as part of the consultation process, as appropriate, before presentation for approval to the relevant approving body.

5.8 Policy Author

a) Ensure that policies are implemented appropriately and, where necessary, audits compliance with those documents.
b) Ensure that all actions listed on the implementation action plan are completed within the timescales set.
c) Ensure appropriate review of the documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, organisational structure or legislation.
d) Ensure comprehensive consultation has taken place with the relevant individuals or groups during the policy development process.
e) Ensure the necessary Equality Impact Assessment is carried out and approved by the Equality and Diversity department prior to entering the approval process and incorporate any necessary amendments to the policy arising from this assessment
f) Ensure that the policy to be presented for approval is sent to the Accountable Executive Lead to seek approval that it may be forwarded for submission to the appropriate Executive Board for approval

g) To send the Trust Secretary the policy and all necessary appendices (see Appendix D). for presentation to the appropriate Executive Board for approval

5.9 Line Managers

a) Ensure staff are aware of and have access to relevant policies and are given the opportunity to comment on draft policies sent out for consultation.
b) Work within approved policies.
c) Ensure staff have read and understood the relevant policies and work within them.
d) Ensure systems exist to identify staff training needs on the implementation of policies and take necessary action to address these where necessary.
e) Audit compliance with policies within the service.

5.10 All Staff

Ensure that they adhere to current policies in use across the Trust and specific to their work. Information regarding the failure to comply with a policy must be reported to the line manager and the incident reporting system used where appropriate.

6 POLICY DEVELOPMENT, APPROVAL AND MANAGEMENT PROCEDURE

6.1 When a requirement for a new policy is identified, the initiator must, in the first instance review existing documents to ensure that the issues are not already covered to avoid duplication.

6.2 Where a new or significantly revised policy is proposed, it should be received initially by the most appropriate corporate Trustwide Committee or Group. Specifically, any policy containing drug prescriptions, or referring to the prescribing of medication, must be checked and agreed by the Drugs and Therapeutic Committee. Following agreement of the policy by the Trustwide Committee/Group the policy should be submitted for ratification by the most appropriate Executive Board. For clinically biased policies, the policy should be considered by the Governance Board. Operationally biased policies should be considered by the Trust Management Board. Subject to the discretion of the Accountable Executive Lead, a policy may also be presented to the Trust Board for approval.

6.3 Where only minor, or no, substantive amendments are proposed to an existing policy, it should be ratified directly with the Accountable Executive Lead without the need for consideration at a meeting. Evidence of this approval must be provided to the Trust Secretary.

6.4 **Policy format and structure:** The Policy Author is responsible for drafting / amending the policy in accordance with the requirements of this policy. The format and structure requirements are set out in Appendix D.

6.5 **Legislation:** The Policy Author must ensure that the policy complies with relevant legislation and good practice. Advice from the Trust's solicitors may be taken via the Trust Secretary or any other manager permitted to take legal advice.

6.6 **Consultation:** The Policy Author must ensure that the key stakeholders (relevant staff, groups, service users and carers) affected by the policy are involved in the consultation process. The Trust solicitors, as arranged by the Trust Secretary, will also where necessary, be involved in the consultation process. The stakeholders with which the Policy Author should consult will be dependent upon the nature of the policy being developed. The process may include seeking views on what the approach adopted by a policy should be or providing a copy of a drafted policy to enable full and detailed consultation to take

place. Contact details of the external bodies and groups of service users with which the author could consult are available from the Head of Communications and Engagement and the Head of Equality & Diversity. The Trust Secretary should be approached for further guidance on the appropriate stakeholders to involve in the consultation, if required.

For new policies and policies that have undergone significant revision, a minimum period of three months consultation is required.

6.7 **Policy length:** Policies should be concise and where possible should not exceed ten sides of A4 in length, excluding the front sheet and appendices.

6.8 **Cross-referencing:** The Policy Author must ensure that where cross-referencing to other policies applies, other Policy Authors are notified as their policies may require amendment as a result.

6.9 **Equality impact assessment:** Draft policies presented for final approval must include a completed initial equality impact assessment (Appendix E) and a full equality impact assessment where required. The equality impact assessment must be sent to the Equality and Diversity team for approval prior to submitting it to the Trust Secretary. Policies will not be forwarded for approval without a completed and approved assessment being received. Always ensure that the latest updated equality impact assessment form is used – a copy must be downloaded from the Equality and Diversity site on the Trust intranet.

6.10 **Auditable standards/Monitoring Effectiveness:** The process for monitoring and measuring compliance with the key elements of the policy must be included within the Auditable Standards section. This must include details of the monitoring system identified, who has responsibility for the monitoring, how and when it will take place and, where shortfalls are identified, the process for ensuring action is taken. The approving body must be satisfied that these are identified and resources are available to conduct the monitoring process before approving a policy.

If a clinical audit is selected as a method of monitoring compliance with the policy:

- Ensure that the relevant staff have previously been informed of the required standards of performance.
- Specify clearly which of the standards are being measured through a structured audit
- Please note that all standards should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**heoretically sound)
- Specify the frequency of the audit.
- Submit the recommended data collection tool to the Clinical Effectiveness Department for approval together with the completed proforma contained in Appendix H.
- Refer to the Clinical Audit Policy before conducting the audit.

Contact the Clinical Effectiveness Department for further advice if required.

6.11 **Implementation:** The Policy Author will develop a plan to implement and embed the requirements of the policy. The action plans should make clear both the actions that have already been completed as part of the preparation for implementing the policy within the Trust, in addition to the timescales and responsibilities for activities planned following approval of the policy. The key actions within the plan should be classified into ‘communications and engagement’, ‘training’, ‘resources’ and ‘monitoring effectiveness & evaluation’.

Confirmation will be sought by the Trust Policy Co-ordinator that all actions in the plan have been completed when the final date in the action plan is reached.

6.12 **Presentation for approval:** The Trust Secretary will arrange for the policy and accompanying supporting documentation to be included within meetings papers being issued to the appropriate Executive Board.

6.13 **Approval:** Authors should ensure that authorisation to present the policy to an approving body is first gained from the Accountable Executive Lead. The approving body must be satisfied that the policy has been developed in accordance with the requirements of this document before they approve a policy. Where a policy exceeds the ten page limitation, the Executive Board must be satisfied that policies longer than this are justified.

Policies may be approved subject to some changes, which the author should make as soon as possible after the meeting at which the policy was considered. The amended version should be sent to the Accountable Executive Lead and the Trust Secretary. Policies requiring considerable amendment should be revised by the policy author and resubmitted to the appropriate Executive Board for approval.

6.14 **Publication and communication:** The Trust Policy Co-ordinator will place a PDF copy of the policy on the Trust's intranet and arrange for notification of the policy approval and key points of or changes to the policy to be included in the daily e-mail communications and 'Hot Topics' bulletins. A MSWord version of the policies will be made available on request from the Trust Policy Co-ordinator.

The Policy Author must ensure that following approval as part of the implementation plan there is sufficient publication and awareness raising with key individuals or staff groups. This is to ensure that the most relevant staff are aware of the revised or new policy requirements and that adequate liaison takes place with relevant managers, clinicians and staff to ensure the effective implementation of the policy. This may include an analysis of training needs.

6.15 **Review:** All policies must be reviewed by the policy author on an annual basis to ensure that the contents remain current. The policy will also be subject to formal review every three years, being resubmitted to the appropriate relevant corporate body for approval. Earlier review may be required in response following any event which highlights the need to review urgently a particular policy or following new legislation, NHS guidance or changes in clinical practice. Should there be a requirement to review formally a policy more frequently than three yearly, the reasons for this should be clearly stated in the policy.

6.16 **Reminder:** The Trust Policy Co-ordinator will provide a reminder to Policy Authors six months prior to a policy's scheduled review date.

6.17 **Retention:** The Trust Secretary will forward an electronic copy of the approved policy with the equality impact assessment to the Trust Policy Co-ordinator, who will retain it centrally. This will be the official copy.

6.18 **Archiving:** When a new version of a policy is approved, the current version available on the intranet will be replaced. The obsolete versions will continue to be retained in a repository maintained by the Trust Policy Co-ordinator for archive purposes. A copy of the superseded policies will be made available on request from the Trust Policy Co-ordinator.

7. CONSULTATION

7.1 An initial draft of this policy was shared with key policy authors and the NHS LA Project Group. A later draft of the policy was issued to the 'All Mailboxes' e-mail distribution list for comment on specific aspects of the revised policy. The outcome of this consultation has

been reflected within this policy where possible.

8. AUDITABLE STANDARDS/MONITORING EFFECTIVENESS

8.1 In order to monitor the effectiveness of this policy the Trust Secretary will undertake to monitor compliance with this policy by reviewing that:

- Policies are submitted in the correct template
- There is evidence that consultation has been undertaken prior to policies being submitted for approval by the relevant Executive Board
- Policies have been presented to and approved by the appropriate Executive Board
- All policies submitted are accompanied by a comprehensive implementation plan and that when the date of the final action in the plan is reached, the Trust Policy Co-ordinator seeks to confirm that the plan has been fully implemented
- Policies approved by the corporate boards are disseminated to all staff via staff communications and to managers via 'Hot Topics' briefings
- There is evidence that a reminder has been issued to Accountable Executive Leads to highlight policies due to expire within the forthcoming six months
- Obsolete policies or policies that have been replaced by updated versions are stored within an archive
- There is evidence that Accountable Executive Leads have provided written consent to minor changes using discretionary authority
- The policy is available for access on the Trust's intranet

9. TRAINING AND AWARENESS

9.1 Managers are responsible for raising awareness of this policy amongst their staff who are involved in writing policies.

9.2 Ad hoc training in the policy development process will be available via the Directorate of Governance, as required, however please refer to the Trust Training Needs Analysis (TNA) for further details as to the training requirements pertinent to this policy.

9.3 Training is arranged to cover the impact assessment process by the Equality and Diversity Team.

10. EQUALITY AND DIVERSITY

10.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.

11. REVIEW

11.1 This policy will be reviewed after three years.

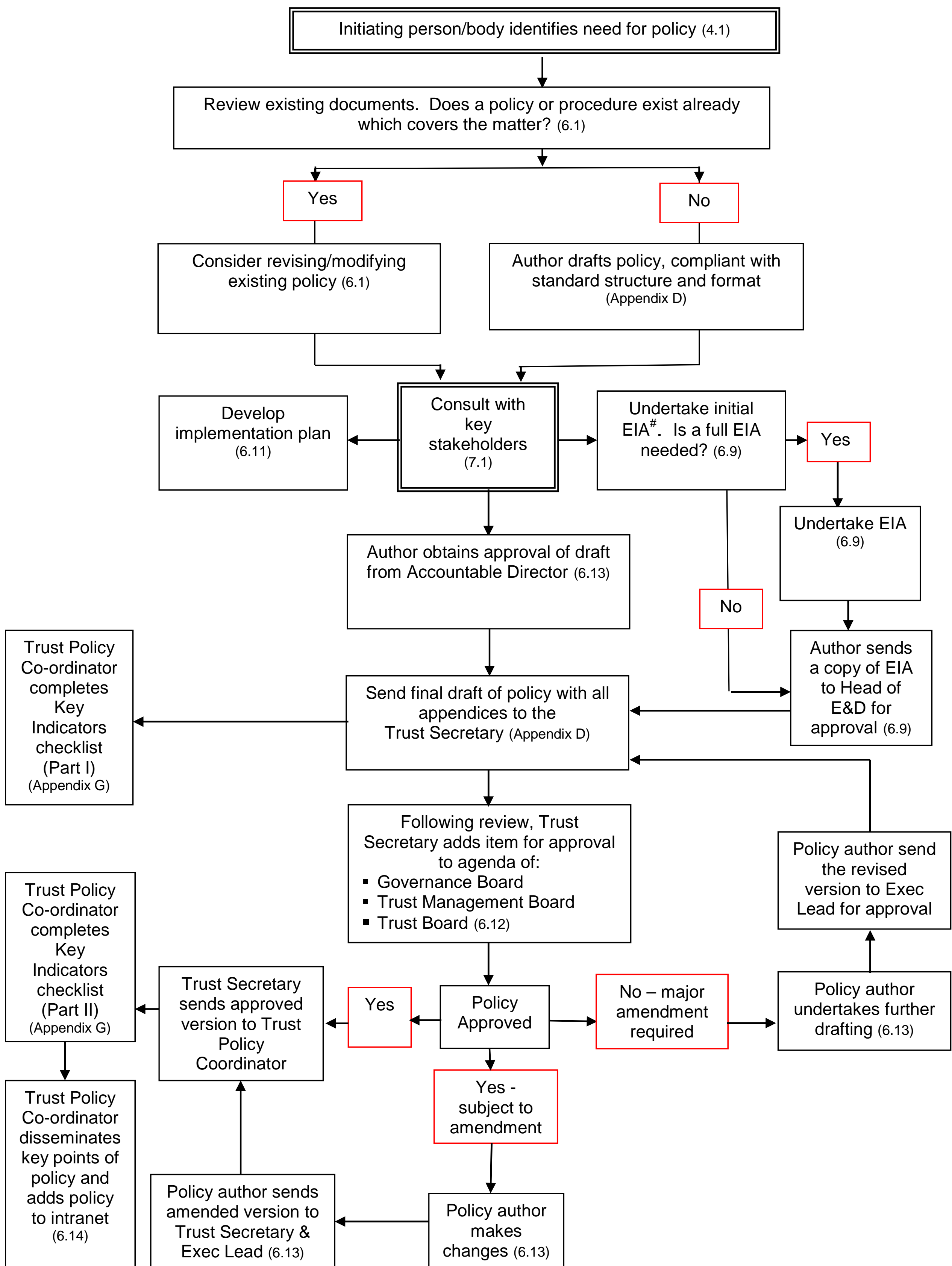
12. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

Reference document – NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care 2011/12

Bibliography – None

13. Further enquiries - details of the individual(s) to whom questions about the policy should be directed.

APPENDIX A – FLOWCHART FOR POLICY DEVELOPMENT AND APPROVAL



#EIA = Equality Impact Assessment
(7.1) = Policy section reference

APPENDIX B – POLICY SUBMISSION PROFORMA

Sandwell and West Birmingham Hospitals
NHS Trust

MEETING NAME

POLICY TITLE:	
ACCOUNTABLE EXECUTIVE LEAD:	
POLICY AUTHOR:	
DATE OF MEETING:	

POLICY STATUS:

NEW POLICY	X	AMENDED EXISTING POLICY	

SUMMARY OF KEY POINTS/CHANGES:

The [name of policy] is presented for approval.

The key points of the policy/changes to the policy# are:

The Board is requested to approve the policy, together with the proposed implementation plan.

The length of the policy is x pages.

CONSULTATION:

The development of the policy has involved consultation with the following groups and key individuals:	
The consultation period started:	[date]
The consultation period finished:	[date]

EQUALITY IMPACT ASSESSMENT:

The development of the policy has involved an equality impact assessment and an initial impact assessment [and full impact assessment#] has been completed and approved by the Head of Equality and Diversity.

delete if applicable

APPENDIX C - FRONT PAGE TEMPLATE

Sandwell and West Birmingham Hospitals
NHS Trust

POLICY NAME

Policy author	
Accountable Executive Lead	
Approving body	
Policy reference	SWBH/XXX/NNN [Assigned by Trust policy-Co-ordinator]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – Name of group
2 – Name of group

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – Name of group

POLICY APPROVAL DATE:
Month and Year

POLICY IMPLEMENTATION DATE:
Month and Year

DATE POLICY TO BE REVIEWED:
Month and Year

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)

POLICY NAME

KEY POINTS

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Contents page

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REVIEW

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FURTHER ENQUIRIES

Appendices

APPENDIX D – POLICY FORMAT AND STRUCTURE

<table>
<tr><td><u>Format</u></td><td>The policy must be prepared in Microsoft Word.
The policy must be prepared using Arial font as follows:
• Title (front page) – Size – 20/bold
• Headings – Size – 11/bold
• Main text – Size 11
The policy footer should include the name of the policy and page numbering in Size 9 Arial font</td></tr>
<tr><td><u>The Title Page</u>

see template at Appendix C</td><td>• Trust logo
• Title of policy

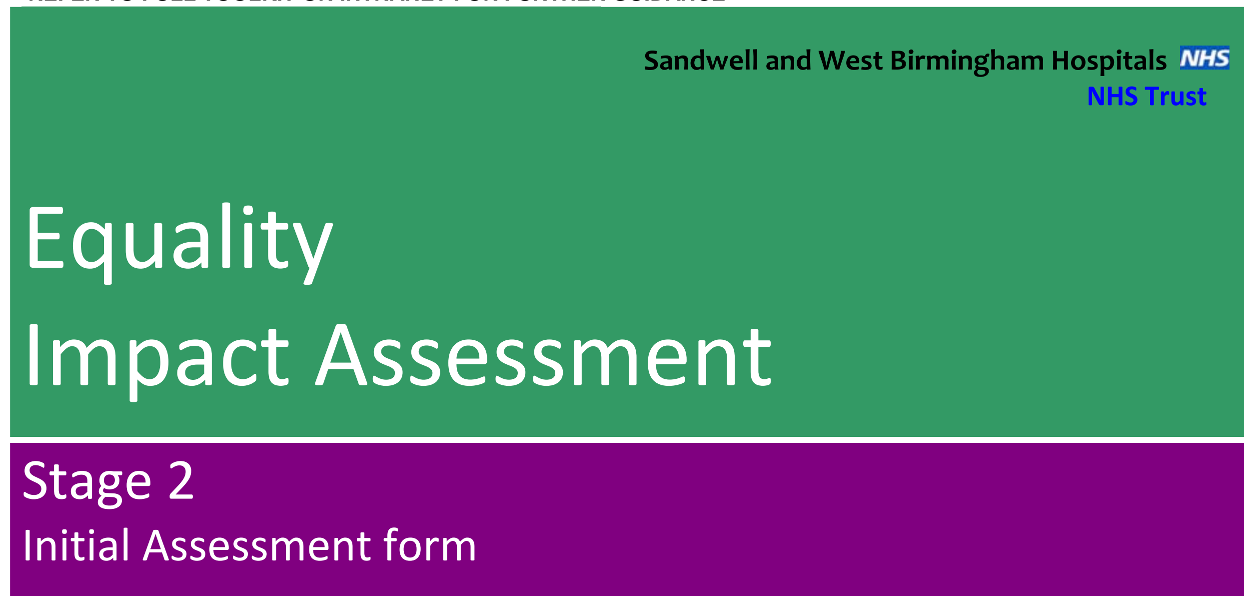
Plus boxed in section containing the following:
• Policy author (title, not name)
• Accountable Executive Lead (title, not name)
• Approving body (Board responsible for approving the policy)
• Policy Reference (unique reference for the policy)

Plus two boxed in sections containing the following:
• Policy approval date
• Policy implementation date
• Date policy to be reviewed
• Key groups of staff to whom the policy applies</td></tr>
<tr><td>The Key Points Page</td><td>No more than one side of A4, outlining the key points of the policy. This is to give the reader a quick briefing on what the policy covers but is not designed to replace the need to read the full policy.</td></tr>
<tr><td>The Contents Page</td><td>• List of sections, headings and page numbers
• List of appendices and page numbers</td></tr>
<tr><td>The Policy</td><td>• Introduction: why the policy is necessary, to whom it applies. It may include reference to any relevant guidelines, statutory requirements or other recommendations
• Cross-referencing other policies: list any linked policies that should be read in conjunction with the policy. This may be referenced to an appendix if necessary.
• Glossary and Definitions: an explanation of any terms used (if extensive, this may be referenced in an appendix)
• Principles: the key policy issues underpinning the need for the document, the aims and standards which are intended to be achieved.
• Roles and responsibilities: List the key duties for members of staff or groups who have a role in delivering the requirements of the policy
• Procedure: consisting of a step-by step account of how the policy is to be achieved
• Consultation: outline the process followed to engage stakeholders in the development of the policy and include details of the individuals and bodies involved
• Auditable standards/process for monitoring effectiveness: outline the process by which compliance with the policy will be monitored, by whom and how often. Include details of the key indicators that will be used to provide the evidence of compliance.
• Training and awareness: provide details of measures by which staff will be made aware of the requirements of the policy. Unless training is to be provided outside of the Training Needs Analysis framework, include a standard statement as follows ‘Details of the training requirements are</td></tr>
</table>

	contained within the Training Needs Analysis, located on the Trust's intranet'. • Equality and Diversity: include a standard statement as follows **'The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the SWBH Equality Impact Assessment Toolkit, the results for which are monitored centrally.'** • Review: Include a standard statement as follows: '**This policy will be reviewed in three years time unless requires earlier review'** • Reference documents and bibliography: a list of works that the author has used as a source, but are not referred to directly in the text. • Further enquiries: provide details of the individual(s) to whom questions about the policy should be directed.
The Appendices	• Additional material necessary to the delivery of the policy. • A flow chart showing the key steps within the policy should be attached where possible. • An Equality Impact Assessment that has is signed off by the Equality and Diversity Team • An implementation plan

APPENDIX E

EQUALITY IMPACT ASSESSMENT TEMPLATE##
##REFER TO FULL TOOLKIT ON INTRANET FOR FURTHER GUIDANCE



The Initial Impact Assessment is a quick and easy screening process. It should:

1. Identify those services, policies, or functions which require a full EIA by looking at:

   - Negative, positive or no impact on any of the protected characteristics.
   - Opportunity to promote equality for the protected characteristics.
   - Data / feedback prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed

Division: ☐

Speciality/Service Area ☐

Is it a Service, Policy or Function: ☐

Lead officer (enter name and designation): ☐

Title of service , policy or function : ☐

Is this service aimed at: Adults ☐ Paediatrics ☐ Both ☐

Existing: ☐
New/proposed: ☐
Changed: ☐

Q1) What is the aim of your service, policy or function (you may want to refer to the Operational Policy for your service)?

Q2) State which Trust strategic objective this service, policy or function relates to:

Q3) Who benefits from your service, policy or function?

Q4) Do you have any feedback data that influences, affects or shapes this service, policy or function?

Yes	No
☐ Please complete below.	☐ Please go to question 5

What is your source of feedback?

☐ Monitoring Data
☐ PALS
☐ Previous EIAs
☐ National Reports
☐ Internal Audits
☐ Patient Surveys
☐ Complaints / Incidents
☐ Focus Groups
☐ Equality & Diversity Training
☐ Equality & Diversity Team
☐ Other (please state)

What does this source of feedback reveal?

Q5) Thinking about each group below does or could the service, policy or function have a negative impact on members of the protected characteristics below?
(Please refer to pages 3 & 4 for further definitions of protected characteristic)

Protected Characteristic	**Yes**	**No**	**Unclear**
Age	☐	☐	☐
Disability	☐	☐	☐
Race	☐	☐	☐

Sex	☐	☐	☐
Gender Reassignment	☐	☐	☐
Sexual Orientation	☐	☐	☐
Religion or belief	☐	☐	☐
Pregnancy & Maternity	☐	☐	☐
Marriage & Civil Partnership	☐	☐	☐
Other socially excluded groups	☐	☐	☐

If the answer is "yes" or "Unclear" please complete a full EIA

Q6) Who was involved in the EIA and how?

Who:

☐ Staff members
☐ Consultants
☐ Doctors
☐ Nurses
☐ Local patient/user groups
☐ Other

Please specify

How were they involved?

☐ Surveys
☐ Team Meeting
☐ Via the Single Equality Scheme
☐ Divisional Review
☐ Other

Please specify:

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	☐	yes	☐

Q7a) If 'No' Explain why you have made this decision?

Q7b) If 'yes' explain the negative impact – you may need to complete a full EIA

If a negative impact has been identified please continue to Stage 3. If no negative impact has been identified please submit your Initial Equality Impact Assessment to SWBH-GM-EqualityDiversity@nhs.net

Please note: Issues relating to either interpreting/translating, ensuring single-sex accommodation or Bariatric issues have been identified as corporate trends, therefore if the negative impact you have identified falls within these categories a full impact assessment is not required. However you must state what reasonable adjustment you have put in place to mitigate the impact temporarily.

Should you go full impact assessment Corporate trends must be included on the action plan (page 19) along with what actions (reasonable adjustments) are being taken locally whilst the corporate trends are being addressed.

Justification Statement:
As member of SWBH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	
Designation:	
Date:	
Contact number:	
Head of Service:	

This EIA has been approved by the Divisional General Manager:

Name:	
Designation:	
Date:	
Contact number:	

This EIA has been signed off by the Head of Equality & Diversity:

Name:	
Signature:	
Date:	
Contact number:	

Step 8) Now that you have ensured a full impact assessment does not need to be completed we need to publish your results for the public to view.

Tick list

☐ Send an electronic copy of ratified EIA to the Equality and Diversity team who will publish it on the website

Equality & Diversity team contact details

- Pauline Richards (Head of Equality & Diversity)
- Estelle Hickman (Equality & Diversity Advisor)
- Maqs Khan (Equality & Diversity Senior Advisor)

You can contact the team by:
Tel: 0121 507 5561 or Email: SWBH-GM-EqualityDiversity@nhs.net

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Equality Impact Assessment

Stage 3
Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Assessment form. This will involve you questioning aspects of a proposed/existing service policy or function and forecasting the likely effect on different groups.

Step 1) What is the impact?

1) Why have you carried out this Full Equality Impact Assessment?

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination or anyone else who will be impacted on by your service, policy or function.

Step 2) what are the differences?

2a) Identify the Equality group(s) that will be affected by the impact and state what the differences are:

Protected Characteristic	**Negative / Potential Negative Impact**	**Positive / Potential Positive Impact**	**How is the Equality group identified affected in a different way to others as a result of the service, policy or function?**
Age	☐	☐	
Disability	☐	☐	
Race	☐	☐	
Sex	☐	☐	
Gender Reassignment	☐	☐	
Sexual Orientation	☐	☐	
Religion or Belief	☐	☐	
Pregnancy & Maternity	☐	☐	
Marriage & Civil Partnership	☐	☐	
Other socially excluded groups	☐	☐	

2b) This EIA indicates that there is insufficient evidence to judge whether there is differential impact. Please state why below.

Step 3) You are almost there - now all you need to do is to consult!

3a) Who have you consulted with on your service, policy or function and when did the consultation take place?

3b) As a result of the consultation are there any further changes to the service, policy or function indicated?

Step 4) Plan to address your Negative Impact

1. It is now time to complete your action plan using the table below. Please detail how you are going to address the negative impact, stating the timescales involved. Please refer to the matrix on pages 11 and 12. When including the rag rating please state how the score was achieved e.g. severity (S) 3 x Probability (P) 4 = 12.

Protected Characteristic	Negative Impact	Negative Impact Rag Rating	Action Required	Cost Implications	Expected Outcome	Lead (name and designation)	Timescale (specify dates)

NB: As a requirement of the Divisional Review process, please ensure that you include the above actions within your Implementation Plan.

Step 5) Congratulations you have made it.

Completed by:

Name:	
Designation:	
Date:	
Contact number:	
Head of Service:	

This EIA has been approved by the Divisional General Manager:

Name:	
Designation:	
Date:	
Contact number:	

This EIA has been signed off by the Head of Equality & Diversity:

Name:	
Signature:	
Date:	
Contact number:	

Step 6) Now we need to publish your results for the public to view.

Please complete the tick list below.

☐ Please tick to indicate that this EIA has been approved by your Divisional General Manager.

☐ Please send your completed EIA to the Equality and Diversity team for approval. Once approved, your EIA will be placed on the SWBH webpage for the public to view.

Please email all EIAs to SWBH-GM-EqualityDiversity@nhs.net

Equality & Diversity team contact details

- Pauline Richards (Head of Equality & Diversity)
- Estelle Hickman (Equality & Diversity Advisor)
- Maqs Khan (Equality & Diversity Senior Advisor)

You can contact the team by:
Tel: 0121 507 5561 or Email: SWBH-GM-EqualityDiversity@nhs.net

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APPENDIX F – POLICY IMPLEMENTATION PLAN

Sandwell and West Birmingham Hospitals
NHS Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	
ACCOUNTABLE EXECUTIVE LEAD:	
POLICY AUTHOR:	
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

IMPLEMENTATION PLAN OWNER: ____

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a						
b						
c						
d						
2	*Training*					
a						
b						
c						
d						
3	*Resources*					
a						
b						
c						
d						
4	*Monitoring Effectiveness & Evaluation*					
a						
b						
c						
d						

Final date when plan is expected to be fully implemented: ____

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

APPENDIX G – KEY INDICATORS CHECKLIST

Policy on Policies - Key Indicators Checklist for Policies Needing Approval by a Board

Policy Name:	
Policy Reference:	
Author:	
Approving body:	
Date of approval:	
Date checklist signed off:	

Key Indicator	Compliant (Y or N)	Comments
Part I - PRIOR TO APPROVAL BY BOARD		
Policy format and structure is correct		
The policy has evidence of approval by the Accountable Executive Lead		
There is evidence that relevant and comprehensive consultation has been undertaken prior to the policy being submitted for approval		
The policy is accompanied by an approved equality impact assessment		
The policy is accompanied by an implementation plan, and actions to be completed are assigned to a clearly identified person and timescales have been set for completion		
If a clinical audit is selected as a method of monitoring compliance with the policy, the policy is accompanied by an approved data collection tool and a completed proforma (Appendix H).		
Part II - AFTER APPROVAL BY BOARD		
Approved policies and equality impact assessments are made available on the Trust intranet which is the primary location for all policies		
Approved policies are also disseminated to all staff via Staff Communications and to managers via 'Hot Topics' briefings		
Obsolete policies or policies that have been replaced by updated versions are stored within an archive		
Confirmation that the implementation plan has been fully completed is obtained		

APPENDIX H

Data Collection Approval Form

(To be used for approval of a data collection form if a clinical audit is specified to measure compliance with processes contained in the policy).

Please attach the data collection form and forward this to the Clinical Effectiveness Department for approval.

Title of draft or revised policy	
Name of person submitting the data collection tool for approval	
Date of submission	

	Policy reference (page number& section)	**Details**
Standards to be measured through clinical audit		
Responsible individual or group/committee for the monitoring		
Frequency of monitoring		
Responsible individual or group/committee for reviewing the results		
Responsible individual or group/committee for development of the action plan		
Responsible individual or group/committee for the monitoring of action plan		

Date of receipt by Clinical Effectiveness	
Date of approval by Clinical Effectiveness	